



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
IDAHO**

**Application for 2008  
Annual Report for 2006**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

Last year Idaho contracted with Health Systems Research to conduct Idaho's 5 year needs assessment. This process included input from various organizations and individuals representing MCH populations. The process included written and phone surveys, focus groups and key informant interviews. See attached needs assessment. In addition to soliciting comments from the general public, members of the Needs Assessment Advisory Committee were asked to review and comment on this year's application. MCH funded programs involve public input as appropriate for program direction and implementation. For example, CSHP's ongoing effort to transition the program from a pay for service to a systems development and maintenance program. The program has coordinated numerous meetings with policymakers, advocates, health care providers and families to begin designing a system that will assure access to specialty health care for CSHCN. Public input will be solicited as we develop strategies to address the priority areas identified in the needs assessment.

## **II. Needs Assessment**

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

*/2008/ A number of factors over the past year have greatly influenced Idaho's MCH Title V program and the State Priorities that were identified in the 2006 application. The coming year will be a time to reflect on the selected priorities and focus the direction of the MCH program.*

*The initial factor impacting the MCH program was the loss of \$1,000,000 in Temporary Assistance to Needy Families (TANF) funds that had been used to support the Idaho Immunization Program. The state legislature generously supported the program with \$700,000 to support the registry system (IRIS) but still left the program short \$300,000 in education and outreach money.*

*The second major factor was an interim gubernatorial change six months prior to our newly elected governor, Mr. C. L. "Butch" Otter, taking office. The interim governor, Mr. James Risch, reorganized the Department of Health and Welfare. Governor Otter kept the changes and has expressed his desire for smaller government and no new programs. Governor Otter is disbanding many of the coordinating councils that had been established under the prior governor. These councils were the key mechanism for receiving input from partners and the public on MCH programs and efforts. The 2005 priorities and our progress are listed below.*

- 1. Pregnant Women and Children: Increase awareness of Medicaid programs for women and children across provider and community networks. No progress has been made in this area.*
- 2. Perinatal Depression. The reorganization of the Department of Health and Welfare resulted in a new division, the Division of Substance Abuse and Behavioral Health. We look forward to partnerships with this Division as we look for provider tools and referral resources to address perinatal depression.*
- 3. EPSDT Screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring appropriate. No progress has been made.*
- 4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups. No progress on this assessment has been made.*
- 5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex needs of all CSHCN. An evaluation of CSHP was done. This included funding, staffing and services provided by the program. The new program manager is now looking more in depth at how services are delivered and how we can strengthen that system to address needs throughout Idaho.*
- 6. Cultural Competency. Division of Health Administrator, Mrs. Jane Smith, RN, is recognizing "Centers of Excellence" within the Division. This will allow us more ready access to the cultural competency expert who is in another Bureau thereby strengthening this aspect of the MCH programs.*

**7. Dental Health:** Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy. We have made excellent progress in our effort to address dental care during pregnancy. Each health district is to the point in the project where they are actively recruiting dentists who will agree to see at least a few Medicaid pregnant women referred by physicians. This is complemented by training in physicians offices on what to look for in a quick screen that would require a referral. This program has been well received by the health districts and the physicians. It continues to be more difficult to recruit dentists to participate. Success will be measured through PRATS data.

**8. Health Education:** Strengthen health education in the public schools, including strategies to assure that school health educators receive up to date training on health topics. During the past year, we were successful with a program called the School Health Partnership. The Division of Health, the Division of Welfare and the Department of Education worked together to place school nurses in Idaho schools without nurses. The project funded 10 full time equivalent nurses, but far more schools received services due to the sharing of resources.

**9. Systems Development.** CSHP is developing a database to meet the needs of all users in the delivery of service to the CSHCN population. Another collaborative effort is the linkage of WIC data, birth certificate data and Medicaid data. We have also increased our efforts to develop and deliver train-the-trainer type programs to sustain programs with minimal or no continued funding such as the Breastfeeding Friendly Workplace project.

**10. Overweight and Obesity:** Develop and implement strategies to reduce the problem of overweight and obesity among school age children. No Title V funding has been directed towards this issue. Activities are through the Idaho Physical Activity and Nutrition Program.

*It is obvious that the above factors coupled with numerous staff changes have not prevented us from making progress towards the ten stated priorities from the Needs Assessment. However, it is also obvious that we must reexamine the stated priorities and determine what we can most effectively impact within our changed circumstances. This process will take place with relevant partners as we move forward. One of the most significant findings from the needs assessment was the necessity for MCH to play a stronger role in systems building. To that end many of the priorities that were chosen were done so based on the desire to strengthen infrastructure, not fully support programs that can not exist when the funding is eliminated. //2008//*

### III. State Overview

#### A. Overview

##### Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and uninhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

##### Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 38th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.

/2004/ The 2001 estimated population for Idaho is 1,321,006.

/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. /2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//

/2005/ Summary of Population by Region (Health District) for 2000  
(April 1, 2000 Census)

##### DISTRICT POPULATION PERCENT

District 1	250,984	19.40
District 2	100,533	7.77
District 3	191,297	14.78
District 4	344,355	26.61
District 5	162,397	12.55
District 6	156,906	12.13

District 7 160,132 12.38

/2005/ Summary of Population by Region (Health District) for 2003  
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT

District 1 265,672 19.44  
District 2 100,348 7.34  
District 3 213,465 15.62  
District 4 369,002 27.01  
District 5 167,444 12.26  
District 6 158,266 11.58  
District 7 168,969 12.37

//2005//

/2007/ Summary of Population by Region (Health District) for 2005  
(July 1, 2005 Census Estimate)

DISTRICT	POPULATION	PERCENT
District 1	201,570	14.1%
District 2	100,465	7.0%
District 3	227,825	15.9%
District 4	389,228	27.2%
District 5	170,617	11.9%
District 6	162,342	11.4%
District 7	177,049	12.4%

//2007//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; 8 native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans reside on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2004/ Racial groups that comprised Idaho's population in 2000 were: (a) white, 91%; (b) black, .4%; (c) American Indian/Alaskan Native, 1.4%; (d) Asian, 0.9%; (e) Native Hawaiian/Pacific Islander, 0.1%; and (f) Other, 4.2%. Hispanics make up 7.9%.

/2007/ Population Estimate, July 1, 2004

Percent of Total Population Estimate in District by Race and Ethnicity

	Total	Race				Ethnicity		
		White	Black	American Indian	Asian and Pacific Islander	Hispanic or Latino*		
Idaho	100.0%		96.4%	0.7%	1.6%	1.3%	8.9%	
District 1	100.0%			97.2%	0.4%	1.9%	0.6%	2.5%
District 2	100.0%			94.6%	0.5%	3.5%	1.3%	2.1%
District 3	100.0%			97.0%	0.6%	1.2%	1.1%	18.1%
District 4	100.0%			95.6%	1.3%	0.9%	2.3%	5.8%

District 5	100.0%	97.9%	0.5%	0.9%	0.7%	16.7%
District 6	100.0%	94.7%	0.6%	3.8%	0.9%	8.2%
District 7	100.0%	97.9%	0.6%	0.7%	0.8%	8.0%

\*Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.

Source: National Center for Health Statistics. Estimate of July 1, 2004 resident population from the Vintage 2004 postcensal series by state, county, year, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; Internet release September 9, 2005.//2007//

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. /2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//

#### Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho (\$36,023) was 9.2% lower than the national average (\$39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//

#### Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

/2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//

/2007/ In 2004, 36.6 percent of people in Idaho 18 to 24 years of age have completed high school (including equivalency). In 2004, 87.3% percent of people 25 years and over in Idaho had completed high school (including equivalency) ranking Idaho 18th.//2007//

## Health Delivery System in Idaho

As a frontier state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

//2007/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult CF clinics are held at St. Luke's, and PKU clinics are held quarterly at the state laboratory in Boise and twice annually at two district health departments. //2007//

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. //2005/ Bed capacity has increased to 3,326.//2005//

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

//2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//

//2007/ There are 10 Community and Migrant Health Centers (organizations) in the state, but many of them have satellite clinics. It is perhaps more accurate to say there are 10 Idaho organizations serving 34 communities (including three communities in Oregon). The 330 grantees aggregately served 88,932 patients in 2005, with 329,228 total encounters (this includes medical, mental health, substance abuse and dental). It also includes 9,255 encounters for "enabling services" (case managers, health educators).//2007//

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 96.

/2006/ As of May 2005, there were 685 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice, General Practice, Obstetrics, Gynecology, Ob-gyn, Pediatrics and General Internal Medicine as their primary specialties.) There were a total of 308 Physician Assistants, 29 Certified Nurse Midwives, 441 Nurse Practitioners and 1,073 Pharmacists licensed and practicing in the state. It is also practical to note that there are 254 licensed Community Pharmacies in Idaho. There were 810 Physical Therapists, 297 Occupational Therapists (and 98 Occupational Therapy Assistants), 57 Psychiatrists and 687 Dentists licensed and serving Idahoans. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2006//

/2007/ As of May 2006, there were 1,170 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 592, General Practice 31, Ob-gyn 140, Pediatrics 131 and General Internal Medicine 276 as their primary specialties.) There were a total of 352 Physician Assistants, 21 Certified Nurse Midwives and 289 Nurse Practitioners. There are approximately 1,700 Pharmacists licensed with the State of Idaho, 1,400 of whom are practicing in the state. It is also practical to note that there are approximately 250 licensed Community Pharmacies in Idaho. There were 846 Physical Therapists, 316 Occupational Therapists (and 98 Occupational Therapy Assistants), 96 Psychiatrists and 716 General Dentists licensed and serving Idahoans, and 884 total licensed Dentists in Idaho. There are 882 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2007//

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

#### Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

/2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health

insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, compared to 12.6% of the U.S. population enrolled in Medicaid. Additionally, the 1998 Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

/2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS

systems that often serve as first encounter points for direct care. Poverty level and low-income populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//

/2006/ Currently, 88.4% of the state's area has a designation as a health professional shortage area in primary care, 88.7% in dental health, and 100% in mental health (Figures 1, 2 and 3).//2006//

/2007/ According to the Morgan Quitno Press, Health Care State Rankings 2006, Idaho ranked 50th for "rate of physicians in 2004" with 193 per 100,000 population. Idaho ranked 49th for "rate of physicians in patient care in 2004" with 161 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2005" with a reported 17.9%. Currently, 90.0% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.9% in Dental Health, and 100% in Mental Health.//2007//

***/2008/ According to the Morgan Quitno Press, Health Care State Rankings 2007, Idaho ranked 49th for "rate of physicians in 2005" with 198 per 100,000 population. Idaho ranked 49th for "rate of physicians in patient care in 2005" with 162 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2006" with a reported 18.0%. Currently, 95.3% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.4% in Dental Health, and 100% in Mental Health.//2008//***

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

/2007/ According to the July 2005 population estimates, U.S. Census Bureau, the population of Camas County is now 1,050 and the population of Clark County is 943. Camas County now has services in Fairfield. Clark County does not have services.//2007//

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/ migrant clinics in north Idaho.

/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//

/2007/ The Bureau of Facility Standards lists 47 certified rural health clinics. There are nine free medical clinics registered with the State of Idaho.//2007//

/2005/ During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care on-site has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 on-site community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//

#### Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

/2007/ During SFY 2005, there were 104,041 children enrolled in Title XIX Medicaid for at least one month of the year and another 12,458 children enrolled in the Medicaid expansion Title XXI CHIP A and CHIP B.//2007//

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000 through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

/2007/ During SFY 2005, the toll-free Idaho CareLine averaged 331 calls per month from persons seeking a Medicaid dentist, down 27 percent from 2005. Calls totaled 3,969 seeking a Medicaid dentist and 741 persons seeking free or reduced dental services. A total of 567 dentists (64%) of 884 dentists with an Idaho license and in-state address had one or more paid Medicaid claims and 325 (57%) of Medicaid billing providers had paid claims of \$10,000 or more. Five Idaho

counties are without a dentist and 11 counties have no Medicaid billing dentist who saw 50 more beneficiaries under age 21.//2007//

/2006/ During SFY 2004, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist, up 86 percent from 2003. Calls totaled 5,459 seeking a Medicaid dentist and 602 persons seeking free or reduced dental services.//2006//

/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

/2006/ During SFY 2004, the average monthly enrollment of eligible children in Title XIX Medicaid was 100,520 and 11,235 in Title XXI CHIP.//2006//

/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5 years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving \$10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically calls each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

/2005/ During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > \$10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area.  
//2005//

//2006/ As of July 2004, there were 807 active licensed dentists with Idaho addresses; 563 (69.8%) dentists had at least one paid Medicaid claim and 319 (39.5%) had paid claims > \$10,000, a substantial increase over 2003. Four of the 44 counties had no enrolled Medicaid dentist. //2006//

#### Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

#### Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program (CSHP). We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

//2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long-term design for the program. Their report was delivered

to the Department in November 1998 for review and submission to the new Governor and Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2003/ The number of providers providing vaccination data to IRIS increased to 100. To date there are over 139,814 patient records.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18.//2005//

/2006/ As of 6/10/05: 253 Health Care Providers, 758 Schools and Daycares are enrolled in IRIS.

265,228 patients total, 3,124,787 vaccinations. 190,712 records are 18 and younger, 74,516 are over 18.//2006//

/2007/ As of 05/29/06: 276 Health Care Providers, 903 Schools and Daycares are enrolled in IRIS in Idaho and 7 providers from border areas in Washington State are also enrolled. 297,554 patients total, 3,739,209 vaccinations. 290,734 records are 18 and younger, 85,422 are over 18. 93% of all Idaho newborns are consented into the Idaho Immunization Registry. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2007//

***/2008/ As of 05/25/07: 298 Health Care Providers, 1,019 Schools and Daycares are enrolled in IRIS in Idaho and 8 providers from border areas in Washington State are also enrolled. 335,911 patients total, 4,290,900 vaccinations. 237,834 records are 18 and younger, 98,077 are over 18. 94% of all Idaho newborns are consented into the Idaho Immunization Registry. We track this differently now so I don't know what you want to include-we know for 2006 that 87% of newborns submitted to vital stats are also consented for IRIS. According to the daily status in IRIS, we currently have 20,231 children under the age of 1 year in IRIS so addition children are being added after being in the hospital. Are we still using 20,000 for the birth cohort or 21,000? Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2008//***

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to Provide leadership for development and implementation of a sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

/2005/ The Any Door Initiative has been piloted in one small office in health district 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in accessing public health services even though they are applying through a social service center.//2005//

/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.

Another project that is included in the FFY 05' budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.

And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs.//2005//

/2006/ Idaho is initiating a project to improve access to prenatal dental care, targeting low income women during their second trimester. This project will seek to achieve two goals, first is to increase referrals by obstetric providers, second to increase the number of pregnant women that actually receive dental services during pregnancy//2006//

***/2008/ During state fiscal year 2007, the breastfeeding coordinator in the WIC program completed a breastfeeding friendly workplace initiative. WIC staff worked with regional breastfeeding coalitions on effective means of working with employers to make simple changes that encourage continued breastfeeding. The coalitions were provided toolkits that they can then provide to employers. //2008//***

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when

we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred direct.

The Newborn Screening Program recently expanded newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia.//2005//

***/2008/ The Newborn Screening Program has expanded to include Cystic Fibrosis testing.//2008//***

#### Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

- Infant mortality and low birth weight
- Adolescent pregnancy
- Vaccine preventable diseases
- Injuries
- Substance and physical abuse
- Investigation and control of "clusters" of reportable diseases and conditions
- Prenatal care utilization
- Children's access to health care coverage
- Risky behavior in adolescents
- Increased data capacity

***An attachment is included in this section.***

## **B. Agency Capacity**

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9). /2006/ Bureau of Health Promotion is now the Bureau of Community and Environmental Health. //2006//

/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Women's Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health.//2005//

/2006/ A new program was added to the Bureau of Clinical and Preventive Services to support the Division of Health's information technology programs including WIC's data base, the Immunization Registry, Health Alert Network, and the National Electronic Disease Surveillance System. This program's primary function is a help desk and to also assist with managing system upgrades and maintenance. //2006//

/2007/ With the resignation of the Health Systems Support program manager in February 2006, and the retirement of one of the employees in April, the management of the IT help desk staff was placed back in the programs, WIC, Immunizations and Office of Epidemiology and Food Protection. //2007//

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2007/ The Child Mortality Review Team was disbanded in 2003. Idaho is aggressively overhauling the EMS patient care reporting system and implementing a trauma registry for hospitals to report on severely injured patients to counter pose against mortality data. The published reports of the CMRT showed that injury was the prevailing issue. //2007//

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse who are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this

collaborative effort.

/2007/ Due to waning attendance, the quarterly MCH meetings were disbanded in 2005. We are trying a new approach of monthly meetings with the Bureau Chiefs of Clinical and Preventive Services, Community and Environmental Health and a representative from the Division of Medicaid. This planning should identify and support opportunities for program integration and enhancement. Others will be brought to the table as is appropriate. //2007//

***/2008/ The Medicaid representative with whom we were regularly meeting resigned and the position was not refilled. There is not currently an individual at Medicaid who functions in a broad capacity and is capable of addressing a wide range of issues. The Bureau Chiefs of Clinical and Preventive Services (MCH Director) and Community and Environmental Health meet regularly and contact personnel from other Divisions as necessary. //2008//***

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

#### Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

#### Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), and biotinidase deficiency, in addition to PKU.

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

/2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//

/2007/ Cystic fibrosis will be added to the newborn screening program in the fall of 2006. //2007//

***/2008/ CF was added to newborn screening testing in June of 2007. //2008//***

Children's Special Health Program.

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

/2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//

/2006/ CSHP rules were revised during the 2005 legislative session. The most significant change was to change eligibility criteria. Previously the program was open to children meeting certain diagnostic criteria regardless of insurance status. The rules have been revised to limit program services to uninsured children only. //2006//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

/2003/ Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

/2007/ Russell Duke, M.S., resigned as Bureau Chief of the Bureau of Clinical and Preventive Services in October 2006. In December 2006, Ms. Dieuwke A. Spencer, R.N., M.H.S. was hired as Bureau Chief. Prior to this position, Ms. Spencer was the Section Manager for Chronic Disease in the Bureau of Community and Environmental Health for a year and previously the Supervisor for the Office of Epidemiology and Surveillance at Central District Health Department in Boise, Idaho where she had been employed for 14 years. //2007//

Susan E. Ault, B.S.N., R.N., A.R.N.P., has been the Family Planning Program Manager since 1988. This program has been re-named the Reproductive Health Program. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

/2006/ Susan Ault has resigned her position and will be working with the Idaho Primary care Association. Her position is presently open for new applicants.//2006//

/2007/ Anne Williamson retired in December 2005 as the STD/HIV Program Manager. Jesus Sandoval, M.S.W. was hired in April 2006 as the Reproductive Health Program Manager. Mr. Sandoval has administrative oversight of the Title X program as well as the STD/AIDS program. //2007//

***/2008/ Mr. Sandoval left the Department in October of 2006. In January 2007 Ms. Kathy Cohen, MS, was hired as the program manager for the Sexual and Reproductive Health Program. She has administrative oversight of the Title X program as well as the STD/AIDS program. //2008//***

Christine Hahn, M.D., has been the State Epidemiologist since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiological support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

/2004/ Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

Leslie Tengelsen, Ph.D., D.V.M., has been the Assistant State Epidemiologist since 1998. She also provides epidemiological support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

/2007/ Dr. Tengelsen's support levels remain the same, funding is at 0.5 of her salary. //2007//

/2003/ Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

/2005/ Jared Bartschi, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//

/2007/ Mr. Bartschi is funded at 0.25 FTE through the MCH block grant. //2007//

/2007/ Meredith Duran, Technical Records Specialist with the Office of Epidemiology and Food Protection, is funded 0.25 FTE through the MCH block grant. Ms. Duran provides support for the e-HARS computer system. //2007//

**/2008/ Meredith Duran has moved to a Technical Records Specialist position with the Sexual and Reproductive Health Program. The position in the Office of Epidemiology and Food Protection is currently vacant and being recruited. //2008//**

/2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//

**/2008/ Brett Harrell retired in December 2006. Mr. Mitch Scoggins, MPH assumed the position of CSHP Manager on May 7, 2007. Mitch has extensive international health experience where he has gained valuable experience in systems change and development. Judy Watson, RN who worked 10 hours per week with the newborn screening program also retired in December 2006. This part-time position has not been refilled. //2008//**

Judy Peterson, M.S., R.D., L.D., provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho WIC Program.

/2004/ Judy Peterson, resigned in July of 2002, but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions.

/2006/ Emily Geary transferred from the WIC program to the Breast and Cervical Cancer Screening Program. Jean Heinz was hired in her place. Ms. Heinz has over 20 years of experience as a Registered Dietitian and most recently worked for the Idaho State Department of Education, Child Nutrition Programs.//2006//

/2007/ In January, 2005, Katie Bagley, RD, LD, was hired in a part-time position to provide dietary and nutritional information to Idaho PKU patients and families. Katie's first several months in the position resulted in quantifiable increases in formula usage by patients, greater patient compliance with monthly phe level blood tests, and positive feedback from families concerning her involvement with and commitment to the health and wellbeing of their children. //2007//

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

/2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger, R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//

***/2008/ Cristi Litzsinger is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.//2008//***

/2006/ Linda Morton has resigned from the Department of Health and Welfare. Cristi Litzsinger was hired in her place. Ms. Litzsinger has 8 years experience working in WIC and is an Internationally Board Certified Lactation Specialist.//2006//

Christina Giso, M.B.A., is Idaho's current MCH State Systems Manager (formerly designated the State Systems Development Initiative Coordinator) and the new Genetic Services Program Coordinator. Her advanced degree is in health systems administration, and her primary focus has been the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

***/2008/ The Immunization Program Manager resigned in February 2007. Ms. Rebecca Coyle, MS, assumed the position and started in April. Ms. Coyle most recently served as a CDC Public Health Advisor to the Minnesota Immunization Program. //2008//***

Bureau of Health Promotion

/2005/ Name changed to the Bureau of Community and Environmental Health.//2005//

Ginger Franks, Dr.P.H., has been the Injury Prevention Program Manager since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

/2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on prevention falls and transitioning the child car safety seat program to other partners.

Kaili McCray has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.//2004//

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.//

/2006/The Adolescent Pregnancy Program has been transferred to the Governor's Office.//2006//

Lisa Penny, B.S., R.D.H., has been Oral Health Program Coordinator since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

***/2008/ Lisa Penny retired in March 2007 after 37 years with the Oral Health Program. Interviews for the Oral Health Program Manager position were conducted in May 2007. //2008//***

#### Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for areas of medical under service, barriers in access to health care, and identification of health

disparities.

Bureau of Health Policy and Vital Statistics

***/2008/ The Bureau Chief, Jane S. Smith, was appointed Division of Health Administrator in January 2007. James Aydelotte assumed the position of Chief, Bureau of Health Policy and Vital Statistics in February 2007. Mr. Aydelotte has been with the Bureau for ten years.***

***Dianna Willis, M.A., has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP) and will soon be the MCH State Systems Manager.***

***/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.***

***/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.***

***/2006/ Dianna Willis recently resigned and the position is currently open for new applicants. //2006//***

***/2007/ Teneale Chaption, M.S., has been the Perinatal Research Analyst (a.k.a. Principal Research Analyst) since July 2005. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Teneale Chaption is the current SSDI Program Manager for Idaho as well as a member of the Association of Maternal and Child Health Programs (AMCHP) and serves on the Advisory Board for the Idaho Perinatal Project. //2007//***

***/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing that is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.***

***/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//***

***/2008/ Mr. Greg Seganos resigned in October 2007. In February 2007 Mr. Ward Ballard assumed the position of MCH research analyst. This continues to be a full time position. //2008//***

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

***/2007/ Patricia Williams is the Idaho CareLine Program Supervisor. //2007//***

## Public Health Districts

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the master's level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

## C. Organizational Structure

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group follows.

### Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing

at St. Luke's Children's Hospital.//2005//

## Children

/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho.//2005//

/2007/ The Bureau of Community and Environmental Health received funding for Comprehensive Cancer planning. //2007//

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

/2007/ Adolescent Pregnancy Prevention has been transferred to the Governor's Office.//2007//

***/2008/ Adolescent Pregnancy Prevention will be transitioning from the Governor's Office back to the Department of Health and Welfare, Bureau of Community and Environmental Health, in July 2007.//2008//***

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on college campuses.//2005//

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho

Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners.//2005//

/2007/ The Injury Prevention Program has transitioned successfully child safety seat distribution and installation and education to state and community partners. The program is currently focusing on fall prevention for the elderly. //2007//

#### Children with Special Health Care Needs.

The Children's Special Health Program (CSHP) provides and promotes direct health care services in the form of family centered, community-based, coordinated care for children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics.//2005//

#### All MCH Populations

The State Epidemiologist provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the Deputy State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCHB EMSC grant.

/2007/ The State Epidemiologist and the Deputy State Epidemiologist provide health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population.//2007//

The STD/AIDS Program provides HIV prevention education activities as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

/2007/ Jared Bartschi oversees contractual performance of the district health departments related to STD and HIV investigations and performs analysis of epidemiologic data. Merideth Duran is involved with the different aspects of data management, including activities to assure data quality and data entry.//2007//

***/2008/ Merideth Duran joined the Sexual and Reproductive Program in May 2007. The interviewing process has begun for Merideth's replacement in the Office of Epidemiology and Food Protection.//2008//***

The toll-free telephone referral service, Idaho CareLine, provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

/2006/ The Idaho CareLine has been designated the 211 Call Center for Idaho. Callers can now access referrals for any health and human service issue by dialing 211 or 1-800-926-2588.//2006//

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

***An attachment is included in this section.***

#### **D. Other MCH Capacity**

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

A 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist staff the CSHP program. In addition, services for PKU and high-risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.2 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

/2006/ The CSHP Manager is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinate genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.//2006//

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

/2006/ The CareLine is now supported by a 1.0 FTE Community Services Coordinator and 6.5 FTE Customer Service Representatives.//2006//

/2007/ The CareLine is supported by a 1.0 FTE Program Supervisor and 9.0 FTE Customer Service Representatives.//2007//

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

***/2008/ Idaho lost TANF funding that was being used to support outreach and education efforts in the Immunization Program. The Division of Health is in discussions with the seven health districts to shift MCH funds within the Bureau of Clinical and Preventive Services programs in order to cover this shortfall. //2008//***

/2006/ The child mortality team has been disbanded. //2006//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

/2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//

In addition to having funding ties to MCH programs there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

/2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//

/2006/ The Adolescent Pregnancy Prevention program is now with the Office of the Governor.//2006//

***/2008/ In July of 2007, Adolescent Pregnancy Prevention will be transferred from the Governor's Office to Department of Health and Welfare, Bureau of Community and Environmental Health.//2008//***

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments have very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

## **E. State Agency Coordination**

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. These agreements refer to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

/2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.

/2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//

/2006/ During FY 2004, legislation changing the Idaho State Dental Practice Act was enacted, creating an extended access endorsement for dental hygienists allowing preventive dental hygiene services to be provided under general supervision in public health settings and allowing retired dentists to provide clinical dental services on a volunteer basis in non-profit dental clinics. Medicaid analyzed the potential cost impact if direct reimbursement were allowed to extended access endorsed dental hygienists. Currently, only district health departments or other entities that employ a dental hygienist can receive Medicaid reimbursement./2006/

/2007/ During FY 2005, Idaho was one of 13 states selected to send a team to the CHCS Purchasing Institute Best Practices for Oral Health Access, held in Philadelphia in September

2005. The MCH Oral Health Program worked with the Division of Medicaid to develop the Idaho application. Information gained at the CHCS Purchasing Institute was timely and useful in developing the oral health component of the proposed Idaho Medicaid Modernization, which emphasizes prevention and disease management.//2007//

/2006/ Women's Health Check cooperates with the Divisions of Medicaid and Welfare to provide treatment for women diagnosed with breast or cervical cancer.//2006//

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. These two federal programs jointly fund the Reproductive Health Program. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient collaboration with the Bureau of Health Promotion with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, oral health promotion, diabetes control, arthritis, and rape prevention. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho CareLine. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

#### Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:

- a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
- b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
- c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
- d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the

implementation of the Individuals with Disabilities Education Act (IDEA), Part C.

- e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
- f) Healthy Child Community, an interdepartmental group interested in promoting the health and well being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
- g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
- h) Idaho Breast and Cervical Cancer Alliance (IBCCA), dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
- i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
- j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
- k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. /2005/ This group is no longer a functioning partnership. //2005//
- l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
- m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
- n) Idaho Governor's Council on Adolescent Pregnancy Prevention. **/2008/ Disbanded by the Governor./2008/**
- o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
- p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
- q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths. /2006/ This group is no longer active.//2006//  
/2004/
- r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding, volunteer networking and operation of the community health center dental clinics. /2006/ Committee no longer meets./2006/
- s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
- t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
- u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
- v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho. /2007/ With the establishment of the Idaho Physical Activity and Nutrition Program, this committee no longer meets. Most participants now partner

with the IPAN program.//2007//

w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.

x) Friends of Children and Families Head Start Health Advisory Committee. /2006/

y) Association of State and Territorial Dental Directors Data Surveillance Committee. /2006/

#### Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the public health districts. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

#### Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Bureau of Health Policy and Vital Statistics, has a cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide immunization status assessments of their clinics as well as identifying barriers to immunization.

/2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//

/2006/ The MOU between Family Health Services and the Idaho Reproductive Health Program is currently in place until January 2006 when progress will be re-evaluated. Success of this partnership has been demonstrated by the 717 clients seen in CY04. In the first quarter of CY05, Family Health Services reported 421 clients have been seen in their clinics for reproductive health care. Eighty-two (82) percent of these clients reported incomes of less than 100 percent of the federal poverty level. An MOU is also in place between Southeastern District Health and Healthwest, a community health center, in Pocatello, Lava Hot Springs, and Downey, Idaho. Clinics in Lava Hots Springs and Downey serve an area with limited pharmaceutical services.//2006//

***/2008/ The MOU's with community health clinics has been discontinued since the clinics can access 340(b) pricing directly.//2008//***

#### Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho

and a survey of medical providers for the Office of Primary Care by Boise State University. The State Epidemiologist collaborated with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university has also been a contractor with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium. Currently, the Immunization Program is contracting with Boise State University and Idaho State University to provide student interns to private immunization providers to assist with the implementation of patient reminder/recall systems for their immunization patients.

/2005/ The Immunization Program no longer contracts with these universities as this program is already implemented.//2005//

## F. Health Systems Capacity Indicators

### Introduction

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	26.1	28.0	28.0	20.0	18.3
Numerator	129	145	153	111	100
Denominator	49406	51875	54629	55482	54564
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

### Notes - 2006

Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

### Narrative:

Idaho does not have hospital discharge data available, so we do not know the discharge rate for children or adults.

In an attempt to address the known contributors to hospitalizations among children (lack of knowledge among care providers, lack of access to medications during school hours, environmental triggers, and in-appropriate diagnosis and treatment), the Idaho Respiratory Health Program (formerly known as the Idaho Asthma Prevention and Control Program) and its partners, Asthma Coalition of Idaho, American Lung Association, Indoor Air Program, Idaho Department of Education, and School Nurses Organization of Idaho, are working with schools to increase awareness among and efficacy of school staff and has developed the School Asthma Management Model for Idaho (SAMMI) that was distributed to all schools in Idaho. SAMMI is an administrative, policy, and educational tool. SAMMI will be evaluated and updated by August 2009, and a tool similar to SAMMI will be designed for and distributed to childcare facilities and

preschools. The Respiratory Health Program and its partners successfully passed legislation to allow children to carry their asthma inhalers and self-medicate while at school. The Respiratory Health Program and the American Lung Association are partnering to provide the Open Airways for Schools program statewide, and the Respiratory Health Program and the Indoor Environment Program are providing Tools for Schools assessments statewide. Over 250 child care providers have been educated in the management of asthma, and approximately 50 health care providers statewide have been trained in the appropriate diagnosis and treatment of asthma. Additionally, the Respiratory Health Program has trained over 300 Head Start staff and 300 Head Start parents in methods to decrease exposures to asthma triggers in the home. The Respiratory Health Program is working to reduce bus and other vehicle idling at schools.

We will continue to educate health care providers through an Asthma Educator Institute with the American Lung Association of Washington, and by systematically promoting the newly revised National Heart, Lung, and Blood Institute (NHLBI) guidelines to all health care providers statewide.

While there is no way to know what impact these interventions may be having on hospitalization rates for children, they are all based on best practices, and have been shown to assist other states in decreasing asthma-related hospitalization rates.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	69.5	70.5	72.6	70.5	68.9
Numerator	14804	15706	16985	16834	15798
Denominator	21296	22276	23406	23865	22930
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2005**

Data Source:

Medicaid

**Narrative:**

The Division of Medicaid is continuing to work on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	54.0	42.9	42.0	38.7	43.3
Numerator	302	210	235	222	632
Denominator	559	490	559	574	1460
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2006**

Data Source: Medicaid

**Notes - 2005**

Data Source: Medicaid

**Narrative:**

The Division of Medicaid continues to work on a project that educates parents and providers regarding well baby clinics. reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly. We will work with Medicaid and monitor this closely as Medicaid Modernization is implemented in Idaho.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	75.6	76.8	74.2	73.9	73.9
Numerator	15187	15955	15814	17247	17247
Denominator	20092	20777	21314	23331	23331
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2006**

In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

**Notes - 2005**

2005 data not available until September 2006.

**Notes - 2004**

In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the

revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

**Narrative:**

Data are for Idaho resident births and are based on records with known data for calculating the Index.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	89.5	94.3	92.5	87.1	88.6
Numerator	127524	142394	150105	128422	124117
Denominator	142425	151017	162240	147366	140163
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

Values reflect numbers of children aged <=19.

**Narrative:**

Medicaid data indicate a downward trend from 2004 and 2005 with a slight increase in 2006. It may be difficult to interpret this change as Medicaid reform is implemented. We will watch this indicator closely as changes are made to Idaho's Medicaid system.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	45.3	48.0	49.2	51.0	55.5
Numerator	11265	14952	16759	15345	19392
Denominator	24864	31177	34068	30069	34939
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2006**

Data Source: Medicaid

Includes Medicaid and Idaho CHIP enrollees only.

**Narrative:**

Medicaid is reimbursing doctors and midlevel providers for topical fluoride applications. Data is from Medicaid. As Idaho implements the Medicaid Modernization Program there will be changes as Medicaid contracts with Blue Cross to cover dental services.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	2726	3077	1949	3244	1194
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2006**

All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Health & Ready to Work website:  
[www.hrtw.org](http://www.hrtw.org)

**Notes - 2005**

All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Health & Ready to Work website:  
[www.hrtw.org](http://www.hrtw.org)

**Notes - 2004**

All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. Medicaid, rather than Title V, pays for all necessary rehabilitation services.

**Narrative:**

Always 0 since CSHP only provides insurance coverage equivalent for children with no source of payment.

**Health Systems Capacity Indicator 05A:** *Percent of low birth weight (< 2,500 grams)*

<b>INDICATOR #05</b> <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>		
			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>

Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	8.1	6.2	6.9
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**Narrative:**

Birth certificate data from Vital Statistics.

**Health Systems Capacity Indicator 05B:** *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	payment source from birth certificate	5.9	5.4	6.2

**Notes - 2008**

B. Idaho resident infant deaths in 2005 and Idaho resident births in 2005. 2006 infant death data are not available as of 6/19/2007. Note: there is a high proportion of infant deaths with payment source for delivery unknown 12.7% (18 out of 142 deaths).

	Medicaid	Non-Medicaid	All
Numerator	43	81	142
Denominator	7299	15007	23064

**Narrative:**

Birth certificate data from Vital Statistics.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	62	76.9	71.7

**Notes - 2008**

Births to Idaho residents in 2006. The methodology to collect data on first prenatal care visit changed in 2004 with the 2004 revision of the Idaho birth certificate. Data in 2006 are not comparable with prenatal care data based on the previous revision of the birth certificate.

	Medicaid	Non-Medicaid	All
Numerator	4750	11906	16773
Denominator	7659	15487	23391

**Narrative:**

Birth certificate data from Vital Statistics.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	66.9	77.8	73.9

**Notes - 2008**

Births to Idaho residents in 2006. The methodology to collect data on first prenatal care visit changed in 2004 with the 2004 revision of the Idaho birth certificate. Data in 2006 are not comparable with prenatal care data based on the previous revision of the birth certificate.

	Medicaid	Non-Medicaid	All
Numerator	5111	12018	17247
Denominator	7638	15450	23331

**Narrative:**

Birth certificate data from Vital Statistics.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2006	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2006	100

**Narrative:**

Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all children's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:

- 1) low-income children and working-age adults
- 2) individuals with disabilities or special health needs, and
- 3) elders or those otherwise dually eligible for Medicaid and Medicare.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 18)	2006	185 185 185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 18)	2006	100 100 100

**Narrative:**

Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all children's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:

- 1) low-income children and working-age adults
- 2) individuals with disabilities or special health needs, and
- 3) elders or those otherwise dually eligible for Medicaid and Medicare.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2006	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2006	100

**Narrative:**

Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all children's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:

- 1) low-income children and working-age adults
- 2) individuals with disabilities or special health needs, and
- 3) elders or those otherwise dually eligible for Medicaid and Medicare.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

**Notes - 2008**

**Narrative:**

The manager of the PRATS program is working on a project linking WIC data, birth certificates and PRATS data.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey?</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis?</b>
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	(Select 1 - 3)	(Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

**Notes - 2008**

**Narrative:**

A weighted YRBS survey was conducted in Idaho in 2005, 2003 and 2001.

In 2005, the total percentage in reporting tobacco use in the past month was 21.4% (Males - 27.1% and Females - 15.9%). In 2003, total use was 17.8% (Males - 20.3% and Females - 15.0%), in 2001 the total was 23.4% (Males - 28.3% and Females - 18.0%). Data source is the CDC website. See State Performance Measure 4 for activities.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted five years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

/2006/ Idaho has just completed it's 5 year needs assessment. A contractor, Health Systems Resarch, performed the needs assessment. The assessment included several meetings with key stakeholder, key informant interviews, focus groups, general and population specific surveys, review of secondary data and a capacity assessment among state level MCH personnel. Priority needs are listed in the next section. //2006//

## **B. State Priorities**

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.
4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

/2006/ Below is a list of priority areas that were identified during Idaho's 5 year MCH needs assessment. They are not in order of priority, but rather a list of the 10 key areas needing attention.

### **Priorities:**

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.
2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.
3. EPSDT screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring as appropriate for all infants, children and adolescents.
4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.
5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex care needs of all CSHCN.
6. Cultural Competency: Improve cultural competency across all programs that work with the Maternal and Child Health population.
7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.
8. Health Education: Strengthen health education in the public schools, including developing strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing system collaboration efforts that focus on defined outcomes for the MCH population. Start building the infrastructure within MCH programs to sustain efforts over time and work to include all MCH partners when planning and targeting efforts.

10. Overweight and obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children. //2006//

### C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		100	100	100	100
Annual Indicator	97.3	95.0	100.0	100.0	100.0
Numerator	20404	19	16	28	17
Denominator	20965	20	16	28	17
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100

#### a. Last Year's Accomplishments

Last year's most problematic part of the NBS process was the number of unusable specimens due to blood-layering, use of capillary tubes, and poor provider planning for kit ordering. Provider education was an ongoing process for the full year with positive results, though there remains room for improvement.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide education/technical assistance to birthing facilities and midwives in all regions of the state.		X	X	X
2. Implement and utilize telemedicine visits for Idaho families with Oregon metabolic consultants	X	X	X	X

3. Add Cystic Fibrosis screening to MS/MS test battery	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Though planned for November '06, Cystic Fibrosis will be added to the MS/MS test battery beginning June 1, 2007.

Pamphlets and educational materials continue to be distributed with birth packets at the provider level, to encourage and maintain high compliance rates.

Confirmed positives are referred immediately to the state genetics program for follow-up by a genetics counselor, who, when appropriate, schedules families to be seen in clinics staffed by metabolic consultants from Oregon Health and Science University.

#### **c. Plan for the Coming Year**

In 2006, we lost the temporary staff person responsible for tracking NBS sample errors and providing birthing facility education to reduce error rates. Since we recognize that these tracking and education functions are essential to ensure timely follow-up for abnormal screens, we are investigating alternative strategies to fill this role in a way that would guarantee the uninterrupted performance of these functions. This may involve contracting for these services.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		60	60	60	60
Annual Indicator	57.2	57.2	57.2	57.2	57.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	60	60	60	60	60

#### **Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### **Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### **a. Last Year's Accomplishments**

Focus group discussions for Idaho's five year needs assessment supported MCHB Chartbook data that indicated a higher percentage of families with Medicaid reported problems obtaining specialty care for their children. Healthy Connections, Idaho's Medicaid managed care program, adds a step in obtaining care that requires parents to visit their primary care provider to obtain a referral to a specialist. CSHP had hoped to meet and work with Medicaid staff last year to address this issue, but the Division of Medicaid is involved with an extensive reorganization, and the upheaval of that process has prohibited any progress with those efforts. It remains a future goal.

CSHP, through a Champions for Progress grant and additional funding from the program to underwrite participant travel and lodging, sponsored four Idaho parents to attend the October Family Voices regional conference. Those parents have become active in the first steps of establishing a statewide network of parent meetings, workshops and mentors for families with special needs children. Idaho was a recipient of a Family 2 Family grant, and CSHP provided funding to assist with the development and stability of that center, which is housed at Idaho Parents Unlimited (IPUL), a parental support organization which is also receiving CSHP funding to help sponsor its annual conference.

A parent representing Idaho Parents Unlimited accompanied State staff to the annual Region X training and grant review in August 2006.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Continue to partner with advocacy organizations to provide technical assistance and funding support.		X		X
2. Work with Medicaid Health Connections staff to encourage simplifying existing program policies for special needs families.	X	X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

2007 has been a year of change within the CSHP. The previous program manager retired at the end of 2006 and the position was unfilled for five months. This lack of continuity and leadership has resulted in a slow-down of activities for the first part of 2007. As the new manager grows into the position, there will be a rapid ramp up of initiatives and follow up.

#### **c. Plan for the Coming Year**

The decision in 2004 to provide CSHP enrollment to only uninsured children who meet the program's nine diagnostic criteria have reduced program numbers from over 3000 to fewer than 300. Transitioning the program from a clinic and direct services orientation to one with a more comprehensive infrastructure-building focus will be a years-long process. Federal estimates indicate a possible total of some 16,000 special needs youngsters in Idaho, and an ongoing challenge to the program will be devising ways to identify these children and families. Funds will be earmarked to provide statewide community-level surveys and other needs assessment techniques in an attempt to locate and identify such families, with the intent of ensuring that they are directed toward services that can meet complex medical needs and are connected with advocacy and support organizations.

A continuing effort to strengthen existing relationships with Idaho advocacy organizations will proceed this coming year, with the goal of making it clear, through policy and action, to all relevant constituencies that CSHP is programmatically and financially committed to working in partnership with families, providers and other agencies/programs.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		50	52	52	52
Annual Indicator	49.1	49.1	49.1	49.1	48.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	52	52	52	52	52

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**a. Last Year's Accomplishments**

Linkages were put in place with the directors of Idaho's AAP and AAFP chapters, and they have both indicated an interest in and willingness to participate in new educational efforts to address the medical home concept through their organizations. The AAP state director will attempt to get medical home education placed on the chapter's priority list of activities for this next year, and is working with incoming officers to move in that direction. Dr. Nancy Mann, a developmental pediatrician at Idaho State University, developed a medical home training for family practice

physicians as part of an AAP CATCH grant, and, as family practice doctors outnumber pediatricians four to one in Idaho, this will be an important constituency to include in education efforts.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue development and implementation of "medical summaries" for use by special needs families and providers.	X	X		X
2. Utilize existing linkages with state AAP and AAFP chapters to address the medical home concept through their organizations.		X		X
3. Explore utilizing medical home training materials developed through an AAP CATCH grant to educate Family Practice physicians.		X		X
4. Explore utilizing the AAP Mentorship Network to provide technical assistance, training and distribution of materials to physician providers.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The medical home concept remains largely unknown or misunderstood in Idaho by providers and families, and significant education needs to take place with both of those groups.

A survey in conjunction with Idaho's five year needs assessment of just over 100 families with children being served by CSHP at the time of the survey indicated that 85% of the respondents felt it was very important to have someone who can coordinate communication between physicians, hospitals and therapists. Data supports that families are explicit about the importance of this area, and given the shortcomings of the medical community in addressing that importance, it remains clear that system-wide efforts are needed to strengthen communication and coordination.

As part of CSHP's attempt to move the program down the MCH pyramid toward more infrastructure-building activity, the tools developed by Dr. Mann will be reviewed to determine which would be most appropriate for inclusion with statewide provider information and education activities.

#### **c. Plan for the Coming Year**

Existing relationships with the directors of Idaho's AAP and AAFP chapters have resulted in an interest in and willingness to participate in educational efforts to address the medical home concept through their organizations. Officers of the Idaho chapter of the AAP have identified medical home education as one of their top five priorities for this year. CSHP has earmarked funds to purchase AAP materials on medical home and early intervention and is working actively with Idaho's Part C program to distribute these materials to providers and parents.

As staff time is available, the development and use of "medical summaries" for special needs youngsters will also be investigated. The basic idea of this approach is taking all of the critical medical information for a child that is usually scattered throughout often multiple medical charts

and placing it into an easy-to-read one page, front and back, document. The summary can then be used by families and physicians to communicate more effectively with other medical and non-medical providers who may not be aware of the many unique needs of a particular child. With a medical summary in hand, a family does not have to repeatedly recite an often lengthy medical history to each provider. The summary can also save sub-specialist physicians valuable time by eliminating the need to pull vital information from charts or replicating costly and time-consuming tests before treatment.

As mentioned previously, tools developed by Dr. Mann will be reviewed to determine which would be most appropriate for inclusion with statewide provider information and education activities.

It remains a goal to utilize the AAP Mentorship Network to provide additional technical assistance, training and distribution of medical home materials to providers. Attempts to identify, recruit and train individual in-state providers to undertake one-on-one communication with their private practice colleagues will accompany this effort.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective			60	60	60
Annual Indicator	53.3	53.3	53.3	53.3	53.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	60	60	60	60	60

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**a. Last Year's Accomplishments**

Significant differences continue to exist between public and private insurance coverage in Idaho. Medicaid expenditures, as in many states, are under regular and increasingly intense scrutiny by legislators. This year, as the possibility of exploring a Medicaid carve out for special needs youngsters was suggested by CSHP, Idaho legislators involved in those discussions did not hesitate to explain that legislative leadership had served notice that no expansion to the Medicaid

budget would be allowed. That information stalled further discussion of the matter.

In an attempt to look at other possible options, two special needs "summit" meetings were held, and a wide variety of invitees to those meetings, who include representatives from the "Blues," providers, families and advocacy organizations, began that process. Medicaid's reorganization, still in process at the time of this writing, will also open previously closed doors to explore a variety of opportunities not possible prior to that new approach.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue attempts to work with Medicaid staff concerning publicizing and successfully enrolling eligible families in the Katie Beckett program.		X		X
2. Continue to use CSHP Summit participants in efforts to identify options for uninsured and underinsured special needs families.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

CSHP is partnering with state advocacy organizations to ensure that every possibility for covering the special needs population is put before Medicaid leadership.

While still far from a certainty, the political climate in Idaho is such that the subject of a Medicaid Carve-out for CSHCN can at least be approached.

Efforts to enact legislation to mandate insurance support of medical foods is also an ongoing effort.

#### **c. Plan for the Coming Year**

The survey of Idaho families as part of Idaho's five years needs assessment indicated that while there are numerous positive aspects of Medicaid coverage for special needs children, there are also numerous challenges that families face in accessing and using Medicaid. One of the most significant of these involves the difficulty families have in finding out about, applying for, and maintaining benefits in the Katie Beckett program. Parents reported that many Medicaid eligibility workers were unaware of the rules for Katie Beckett and were unable to assist them with applying. This has been an ongoing problem in Idaho, and it is hoped that CSHP staff will be able to initiate meetings with Medicaid policy staff to explain the issue and begin the process of exploring possible remedies.

CSHP also will work to be a catalyst pertaining to insurance issues through partnering with families and advocacy groups to explore alternative sources of medical insurance for special needs children. One important resource mentioned in last year's narrative involves the Health

Insurance Guidebook developed in Wisconsin by ABC for Health. Discussion with the group will continue to explore the possibility of developing an Idaho-specific version of the Guidebook.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		77	80	80	80
Annual Indicator	75.2	75.2	75.2	75.2	75.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	80	80	80	80	80

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

Focus groups with CSHCN families held as part of the five year needs assessment revealed that many parents with insurance who were no longer enrolled in CSHP reported a significant lack of coordinated services. Parents reported that it was difficult to find updated information about programs, services and eligibility for other resources. Even during the focus groups, families were updating each other about changes in programs and suggesting ways to find information and services.

The needs assessment provided additional confirmation that Idaho's Medicaid care coordination system leaves much to be desired when it comes to assisting children with complex medical issues. Focus group participants expressed a clear need for care coordination services, but reported very mixed experiences with individual Medicaid care coordinators. Parents were confused about just what services these care coordinators were supposed to provide, and some reported that they did not find coordinator's advice useful, did not find them respectful, so they stopped using their services. Parents who participated in focus groups were also worried that while medical care was still available to their children, support services were more likely to be limited and the lack of experience of care coordinators with complex medical issues would be problematic. Such anecdotal information only serves to verify the need for CSHP to provide technical assistance, training and education to contracted Medicaid care coordinators.

Discussion occurred with the leadership of Family Voices and Idaho Parents Unlimited (IPUL) to include information about this issue with the other initiatives CSHP hopes to undertake with them this coming year. Family Voices and IPUL agreed to assist CSHP with identifying community individuals and groups that are already involved with families in various ways, and those local contacts will strengthen efforts to address this issue.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with public and private insurers to provide training and information to care coordinators about the complexities of special needs children.	X	X		X
2. Utilize and build upon existing relationships with advocacy and support organizations to provide educational and information materials through meetings, conferences and newsletters.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

2007 has been a year of change within the CSHP. The previous program manager retired at the end of 2006 and the position was unfilled for five months. This lack of continuity and leadership has resulted in a slow-down of activities for the first part of 2007. As the new manager grows into the position, there will be a rapid ramp up of initiatives and follow up.

**c. Plan for the Coming Year**

As CSHP continues to move its focus to infrastructure development from the provision of direct services, work will continue this next year in all areas already identified.

As Idaho's Medicaid program finalizes its reorganization, it is hoped that opportunities to expand and strengthen strategies identified above will also provide a road map for new activities. CSHP will be able to bring both financial and technical resources to this important challenge. Idaho Blue Cross has also indicated an interest in addressing shortcomings, from a family perspective, in its care coordination activities and CSHP will join advocacy organizations in those discussions with Blue Cross.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		6	6	6	6

Annual Indicator	5.8	5.8	5.8	5.8	1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6	6	6	6	6

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. Prior years reported the national measure rather than Idaho's measure.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

The Idaho team that attended the 2004 Champions for Progress meeting in Utah had the opportunity to meet with staff from Healthy and Ready to Work, and will plan to utilize information and assistance available from that group. Resources from HRTW's website will provide assistance in terms of data and other tools that can be used in planning strategies for this performance measure.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. As staff time is available, secure and utilize information and technical assistance from Healthy and Ready to Work		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

2007 has been a year of change within the CSHP. The previous program manager retired at the end of 2006 and the position was unfilled for five months. This lack of continuity and leadership has resulted in a slow-down of activities for the first part of 2007. As the new manager grows into the position, there will be a rapid ramp up of initiatives and follow up.

#### c. Plan for the Coming Year

This performance measure continues to be a major challenge for CSHP, and lack of progress is due primarily to a lack of CSHP staff to address the issue in an ongoing manner and the roadblocks inherent in working productively with another bureaucracy. CSHP will continue attempts to work with Idaho's Division of Vocational Rehabilitation to better address these issues.

As mentioned previously, there are plans to utilize information and assistance available from Healthy and Ready to Work. Resources from HRTW's website will provide assistance in terms of data and other tools that can be used in planning strategies for this performance measure.

Plans also remain in place referring to activities that include working with youth-oriented agencies and organizations to encourage ways to connect disabled young people to each other and adult mentors, working with state Independent and Developmental Disabilities councils to explore collaborative efforts, identifying and working with state condition-specific agencies and programs, finding ways to connect CSHP with youth leadership organizations such as 4-H, Special Olympics, and community parks and recreation programs.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	76	77	80	81	82
Annual Indicator	69.4	79	80.8	78.1	76.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	83	84	85	86	87

#### Notes - 2006

NIS data for CY2006 is not available until August, 2007

The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

#### Notes - 2005

NIS data for CY 2005 is not available until August, 2006.

#### Notes - 2004

The percentage comes from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

#### a. Last Year's Accomplishments

The Immunization Program completed provider education conferences. These are regional conferences held throughout the state, focused on vaccine management and safety, provider education, reminder/recall of patients due for immunizations, parent education. The Program also

continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record to verify they are up-to-date. The program continued to monitor immunization coverage levels within the Medicaid population.

The IIP conducted quality assurance reviews to 60 percent of VFC providers in 2006. IIP was unable to meet the goal of visiting all VFC providers due to staffing shortages. Strategic planning for the program was started in 2006.

The program has added two new vaccines to its universal offerings, Rotavirus; a vaccine that helps protect infants against Rotavirus disease, and a second dose of Varicella now offered in a combination vaccine that protects against Measles, Mumps, Rubella and Varicella.

The IIP continued to offer immunization training opportunities to medical assistant and nurse training programs through the state.

The Immunization Program provided free vaccines to immunize all children 0 through 18 years of age at public and private provider sites through out Idaho. This activity has had a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). The Immunization Program continues to see an impressive rise in the number of children receiving the following vaccines: varicella (chickenpox), Pnuemococcal (Prennar) and Hepatitis A. This progress can be related to the amount of education provided by the program to providers as well as providers feeling empowered to educate parents.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccine to all children 0 through 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Perform annual site visits to VFC providers and conduct provider education.			X	
3. Provide parent, school and daycare education, media and training.			X	
4. Maintain an immunization registry, which includes data quality monitoring.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The Immunization Program is working with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program is working closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program is developing a marketing plan that will identify areas that will help to improve immunization coverage levels.

The Immunization Program has contracts with the district health departments to investigate

reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth.

Quality assurance reviews will continue with the goal to visit half of all VFC providers in addition to providers that received a plan of correction during their previous visit. The Idaho Immunization Program is also working to improve training opportunities in Medical Assistant and Nurse training curriculum.

### c. Plan for the Coming Year

The Immunization Program will continue to provide vaccines to children 0 through 18 free of charge to the public and private providers in the state. IIP will propose universal funding of the new Human Papillomavirus (HPV) vaccine. Development of proactive strategies to sufficiently fund this vaccine strategy are currently underway. The Idaho Immunization program will develop and implement a marketing plan that will identify and address barriers to immunizations, and plan for working more directly with parents empowering them to take charge of their child's immunization status, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts. In addition, the IIP will continue to expand its training efforts of Medical Assistants and Nurses.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

During FY 2008, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series. The Immunization Program will implement a Hospital quality assurance program that will address standing orders for the birth dose of hepatitis B vaccine.

Additionally, during FY 2008, the Immunization Program will continue a population-based implementation program to increase Hepatitis A and Varicella immunizations by (1) targeting children 1 to 18 years of age to have two doses of hepatitis A vaccine and 1 Varicella; and (2) providing all vaccines at no cost as part of its general statewide distribution.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program will continue to conduct or contract for activities in four major areas: (1) parent education; (2) provider education; (3) reminder/recall; and (4) childcare and school education.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	17	16	15	14	13
Annual Indicator	18.4	17.5	16.8	16.8	18.8
Numerator	582	545	525	532	597
Denominator	31561	31176	31340	31738	31738
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	15	14.8	14.5	14.3	14

#### Notes - 2006

Population not available until July 2007. Used population estimate from 2005 as estimated denominator

#### Notes - 2005

Data will be available September 2006.

#### Notes - 2004

Data from Idaho birth certificate data available due to revisions in birth certificate for 2004. Data will be available September 2005.

#### a. Last Year's Accomplishments

Reproductive health clinics around the state served a total of 3,465 teens ages 15 - 17 in CY2006. These clients all received physical assessment, education and counseling services. Idaho's teen pregnancy rate for 15-17 year olds is provisionally 18.8, an increase from the previous three years.

All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STD prevention.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Farmway Village Project	X		X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

All health districts have formed partnerships with the Adolescent Pregnancy Prevention Project, an abstinence based organization funded by the Office of Adolescent Pregnancy Programs and State of Idaho Governor's Council of Prevention and Adolescent Pregnancy. The "Peers Encouraging Abstinent Kids" (PEAK) Program was initiated in Northern Idaho and has since been implemented in every health district in Idaho. The goal of the program is to teach 6th, 7th and 8th grade students how to resist peer and social pressures to become sexually active through abstinence education in the school system.

The Adolescent Pregnancy Prevention Project continued to conduct statewide print, television, and radio commercials to promote sexual abstinence.

All of the local health districts have active advisory boards within their reproductive health programs which guide the content of education materials and provide direction for outreach activities. All of these advisory boards have committee members of various backgrounds such as faith based members as well as teen representation.

All health districts provide extended clinic hours in the evening in order to accommodate teen clients. Confidential family. Confidential family planning services are provided for teens in all Idaho Title X clinics.

### c. Plan for the Coming Year

The current Governor has disbanded the Governor's Council of Prevention and Adolescent Pregnancy. The Adolescent Pregnancy Prevention Program will be moved out of the Governor's Office to the Bureau of Community and Environmental Health. With the loss of federal funding, the program is currently supported with TANF and state general funds. When the program moves in July, evaluation and funding will be considered in future program direction.

With the merger of the Reproductive Health program and the STD/AIDS program into one functioning and overlapping program, the prevention effort will be increased. Staff time is being added in order to promote more time and focus on prevention messages as a whole, including those targeted at the teen population. Comprehensive messages will be developed that target teens and encompass issues such as abstinence, STI's, parental involvement, sexual coercion, and birth control methods.

The local health department in Southwest Idaho will continue to conduct a series of bi-monthly sexual education classes on the Farmway Village campus. The Migrant Farm Worker Housing Development (Farmway) is a well utilized project of the county which houses 1,500 -- 2,000 Hispanic migrant farmworkers and families during the course of a year. This education targets adolescents 13-19 and young adults 20-30. The classes are presented by a bi-cultural, bi-lingual nurse.

### **Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	50.5	60	62	64	66
Annual Indicator	59.7	49.9	50.1	55.7	55.7
Numerator	11430	9426	370	10315	
Denominator	19147	18890	739	18527	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>

Annual Performance Objective	60	60.5	61	61.5	62
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**Notes - 2006**

SMILES survey used to estimate not conducted in 2006. 2005 rate used as estimate.

**Notes - 2005**

Data Source 2005 Smile Survey

**Notes - 2004**

Data is from a survey of every third grade class in Idaho Falls school district # 91. State representative data will be available in 2005 from the Idaho State Smile Survey.

**a. Last Year's Accomplishments**

Contracts with the seven district health departments continued to provide dental sealants, fluoride varnish, and in some districts, the fluoride mouth rinse program. Smile Clinics were held throughout the state at elementary schools. This year as an alternative site, clinics were held at the Apollo College, a technical college that houses a dental hygiene program. The Smile Clinics included oral health education, dental screenings, prophylaxis and/or fluoride treatments as well as dental sealants. Additional funding was provided by Regence Blue Shield of Idaho to expand the dental sealant program into some of the most rural counties in northern Idaho. Media surrounded these events to bring awareness to the need for children's dental health. At these events, 'Plaque Smackers' dental packages were provided to all students and volunteers who assisted. Overall, 614 children received sealants during 2006.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for district oral health programs will be maintained at the current level.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

New dental sealant projects have been developed in rural areas of the state. These programs are providing screening days to first identify who needs sealants and then scheduling the children in need for follow up. In one area of the state, nearly half of the children (k-2nd grade) who were screened needed follow-up. Education to parents continues through schools and health districts informing parents of the need for good dental health for their children.

Lisa Penny, the Idaho Oral Health Program Manager, retired this year after 37 years of service. The contracts were developed before she left and so the scope of services that have always been provided remain in effect through this calendar year.

**c. Plan for the Coming Year**

Given the change in management of the Oral Health Program at the state level, the future scope of the program may be evaluated. It is anticipated that much of the services being contracted out to the local health districts for oral health services will be maintained, but it may be an opportunity to move the program into a new phase if the need is determined.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	5	5	4.5	4	4
Annual Indicator	5.6	6.8	5.5	5.8	4.2
Numerator	17	21	17	18	13
Denominator	305614	307803	308270	308945	308945
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	4	4	4	4	4

**Notes - 2006**

Death count preliminary total from ISP for 2006

Population count for 2006 not available until July 2006, 2005 population estimate used as estimate.

**Notes - 2005**

2005 data not available until September 2006.

**Notes - 2004**

Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

**a. Last Year's Accomplishments**

The Injury Prevention Program and health districts statewide transitioned the distribution of child car safety seats, and the training necessary to install those seats correctly, to state and local partners. The health districts are currently worked with area partners and organizations to transition the child car safety seats program to local partners who are willing and able to house the program. All districts will have completed this transition.

During the 2007 legislative session, the fine for not wearing a seatbelt was increased from \$10 to \$25. Legislation making seatbelt use a primary offense did not pass.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Although the Injury Prevention Program will continue to				

monitor mortality rates for those 14 years and younger caused by motor vehicle crashes, it will shift focus to falls among elderly.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

There are currently no activities addressing the rate of deaths to children 14 years of age and younger due to motor vehicle crashes. The Injury Prevention Program has narrowed its focus and solely address fall prevention among those 65 and older.

#### c. Plan for the Coming Year

We will continue to monitor the rate of deaths to children 14 years of age and younger due to motor vehicle crashes. IDHW will continue to support relevant legislation.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					50
Annual Indicator				49.8	50.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	51	51.5	52	52.5	53

#### Notes - 2006

Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would the results of weighted survey sample data.

#### Notes - 2005

2005 CDC National Immunization Survey data only shows rate. Numerator and Denominator not available.

Data Source:

[http://www.cdc.gov/breastfeeding/data/NIS\\_data/data\\_2005.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/data_2005.htm)

#### **a. Last Year's Accomplishments**

- 1) The Breastfeeding Basics handout series was updated with the assistance of hospital lactation consultants and other community providers in breastfeeding care. The handouts contain breastfeeding information based on current research, are easy to read and understand for low literacy population and adult learners, are professional in appearance via the assistance of a graphic designer, and are available in English and Spanish.
- 2) The Idaho WIC Program continues to promote breastfeeding initiation and support efforts for an increase in the duration of breastfeeding among infants. During FY07, Idaho continued to provide and update breastfeeding resource and referral information to healthcare providers, childcare centers, WIC agencies, and worksites around the state. The Idaho Department of Health and Welfare website was updated with current resources and trainings available around the state.
- 3) The Idaho Perinatal Project Annual Conference was held in February 2007. Breastfeeding coalition members, healthcare providers, and WIC staff from around the state attended. The Idaho WIC Program sponsored Dr. Nancy Wight to present on the topics Breastfeeding in the Premature Infant and Substance Abuse During Pregnancy and Breastfeeding.
- 4) As an example to employers around the state, the Department of Health and Welfare implemented a workplace breastfeeding policy. A letter of support for the project was signed by the director and included in the toolkit. MCH grant funds were used to assist Local Breastfeeding Coalitions around the state to implement Healthy Perks for Moms Who Work. The CDC recognizes support for breastfeeding in the workplace as an evidence-based intervention. Local Breastfeeding Coalitions around the state conducted needs assessments of major employers for current practices that support breastfeeding mother's who return to work. A train the trainer workshop was provided. A toolkit was developed and coalitions provided trainings to their area employers on becoming breastfeeding friendly.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Designate employers as Breastfeeding Friendly			X	
2. Evaluate Breastfeeding Friendly Employer Project.				X
3. Evaluate smoking cessation and breastfeeding educational handouts available.				X
4. Provide Breastfeeding Best Practice Grants for higher level staff training and World Breastfeeding Week community activities.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

- 1) Employers around the state are receiving the designation of Breastfeeding Friendly including hospitals, health departments, and businesses.
- 2) The Breastfeeding Coalitions are evaluating the project and suggesting ideas for improvement and how they can provide the education and support on an ongoing basis.
- 3) The State Breastfeeding Workgroup will be reviewing and evaluating educational handouts available on smoking cessation and breastfeeding. According to 2003-2005 PRATS (Pregnancy Risk Assessment Tracking System) data, smokers are less likely to initiate breastfeeding and breastfeed for a shorter duration.
- 4) The State WIC Program continues to provide Local WIC Agencies with Best Practice Grants to achieve higher standards in breastfeeding education and support. Part of the grant requires implementation of World Breastfeeding Week activities.

**c. Plan for the Coming Year**

- 1) In FY07, the State Office will continue to support efforts of Local Breastfeeding Coalitions to provide trainings that attract healthcare professionals and community members who work with populations that would benefit from breastfeeding education to meet specific needs for their area.
- 2) The State Office will continue to provide Healthy Perks for Moms who Work Toolkits to area Breastfeeding Coalitions so that they may train area employers.
- 3) The State Breastfeeding Workgroup plans to implement educational materials that discuss the importance smoking cessation with pregnant/postpartum women who plan to breastfeed.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	82.5	100	100	100	100
Annual Indicator	96.8	93.9	94.2	94.6	98.4
Numerator	18275				22302
Denominator	18886				22657
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2006**

Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data.

Responses indicating that the baby was tested after hospital discharge or that the baby was not born at a hospital but was tested were not included in the denominator.

#### Notes - 2005

Data Source: Vital Statistics

#### Notes - 2004

Note: Responses indicating that the baby was tested after hospital discharge or that the baby was not born at a hospital but was tested were not included in the numerator and "Unsure" responses and responses with no data for that question were not included in the denominator.

Note: PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho.

PRATS data showing only the indicator.

#### a. Last Year's Accomplishments

During CY 2006, 25 infants were identified with sensorineural hearing loss; one of these infants was identified with a mixed hearing loss (includes permanent sensorineural loss and conductive loss), and 8 infants were identified with fluctuating conductive loss.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for the Newborn Hearing Program will be maintained at the current level.			X	X
2. Match or exceed the national benchmarks set by JCIH.			X	
3. Increase family to family support and access to information to assist families.		X		
4. Expand newborn hearing screening to other community-based sites, e.g. district health departments.			X	X
5. Increase and improve the participation of physicians in EHDI and in the provision of a medical home.				X
6. Participate in Early Years Conference to educate early interventionists and other service providers involved in Idaho's EHDI Program.		X		
7.				
8.				
9.				
10.				

#### b. Current Activities

The program continues to work with its partners, including the hospitals, Infant Toddler Program, Idaho Chapter of AAP and other organizations to assure that babies who do not pass the two-stage screening are referred promptly for and receive diagnostic testing. The program continues to increase its efforts to ensure that these children receive timely early intervention services.

#### c. Plan for the Coming Year

The Title V agency will renew the memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing to provide services related to newborn hearing screening. The Consortium's Early Hearing Detection and Intervention will be in its 8th year of funding, and will

continue to be supported by federal funding, integrated with the Infant Toddler Program (Idaho's Part C Program) dedicated to providing early intervention services to children age 0 to 3; meet or exceed benchmarks established by the Joint Committee on Infant hearing on a statewide basis, and have 70% of hospitals achieving the benchmarks on 3 or more of the 4 performance measures.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	12.1	12	12	12	12
Annual Indicator	13	13	13	13.0	11.4
Numerator				19177	44995
Denominator				147366	394435
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	11.2	11	10.8	10.6	10.4

**Notes - 2006**

Source: U.S. Census Bureau

Current Population Survey, Annual Social and Economic Supplement, 2006

[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

**Notes - 2005**

Data Source: Census.gov

**a. Last Year's Accomplishments**

In mid-2005, Idaho began to design a modernization plan to increase program quality and achieve fiscal sustainability. The plan was to create Medicaid eligibility categories and benefit plans based on identified health needs. The plan included program administration reforms and included SCHIP populations. Idaho proposed to use federal Section 1115 waiver authority for reform.

A concept paper was presented to the CMS in July 2005. In February 2006, the Idaho Medicaid Simplification Act was introduced in the Idaho Legislature along with a package of companion bills. The Governor signed the Simplification Act into law on March 31, 2006. Idaho submitted a Section 1115 waiver request on April 24, 2006.

Concurrent to Medicaid reform planning efforts in Idaho, Congress created and passed the DRA. The DRA was signed by the President on February 8, 2005. On March 31, 2006, the Secretary of the U.S. Department of Health and Human Services issued guidance to states on DRA impacts to Medicaid. CMS recommended in late April 2006 that Idaho use DRA provisions to authorize

program reforms instead of a Section 1115 waiver.

Section 6044 of the DRA allows the use of "benchmark" benefit plans that may consist of different benefits rather than "standard" Medicaid. This provision allowed Idaho Medicaid to create tailored benefit plans:

- 1) for low-income children and working-age adults,
- 2) for individuals with disabilities or special health needs, and
- 3) for elders or those otherwise dually eligible for Medicaid and Medicare.

These benchmark benefit plans align services with the health needs of participants. These benchmark benefit plans also serve as three separate eligibility plans for different Medicaid and SCHIP groups. Idaho secured federal authority for these benchmark benefit plans in May 2006 through the DRA and amendments to Idaho's State Plan for Medical Assistance.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement expanded CHIP coverage.				X
2. Work toward gaining expanded Medicaid coverage for young women of reproductive age.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The greatest challenge has been implementing reform provisions of the Idaho Medicaid Simplification Act. However, Idaho is making progress by eliminating gaps in service coverage through the adoption of the Idaho Medicaid benchmark benefit packages. Idaho has also removed the asset test (resource limit) from all children's Title XIX and Title XXI programs.

**c. Plan for the Coming Year**

Idaho intends to institute co-pays for inappropriate use of emergency room and emergency transportation services. This is to increase personal responsibility and awareness of the cost of these services. Idaho also intends to implement a disenrollment protection for children in families who are required to pay monthly premiums for program participation. This increases use of preventive services and provides a safety net for families who may need assistance in making payments.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					26
Annual Indicator				28.9	32.1

Numerator				5240	5807
Denominator				18137	18113
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	31	31	30.5	30.5	30

#### Notes - 2006

Based on PedNSS data avail as of 1/16/2007

Changes in unit conversion measures and BMI comparison data from 2005 reduce comparability with previous data. Using method for 2006 data values for previous years would be:

2002 29.0 percent  
2003 28.2 percent  
2004 29.4 percent  
2005 31.3 percent

#### a. Last Year's Accomplishments

The evaluation of the Idaho Fit Kids Project was completed.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Share performance measure with Local Agency WIC Coordinators, The Idaho Association of Pediatrics, and the Idaho Physical Activity and Nutrition Program.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

1. Discussion for future project ideas with the Idaho Physical Activity and Nutrition Program.
2. Share evaluation of Idaho Fit Kids Project with partners.

#### c. Plan for the Coming Year

Plans for follow-up projects will be identified and considered.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					8
Annual Indicator					9.4
Numerator					2257
Denominator					24108
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	8	7.8	7.7	7.6	7.5

**Notes - 2006**

Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status.

**Notes - 2005**

2005 data available in September 2006.

Data Source: Vital Statistics

**a. Last Year's Accomplishments**

The Keep Infants Safe from Smoke (KISS) project was developed. This project is a collaborative effort between the Idaho Tobacco program and the Idaho Asthma Program. It is targeted at new mothers who either smoke or live with a smoker. The plan includes providing the mother with educational packets which address the harmful effects of tobacco smoke. Mothers will be provided with smoking cessation education. Focus groups were conducted with women who participate in the WIC program to review the educational materials to be provided.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Alcohol, tobacco, and other drugs initiative.			X	X
2. Provide family planning services to educate pregnant women on the risk of tobacco use.	X		X	
3. Provide WIC services to pregnant women.			X	
4. Continue tobacco cessation classes at local health districts.			X	
5.				
6.				
7.				

8.				
9.				
10.				

#### **b. Current Activities**

The KISS pilot project began. The pilot is being conducted in three regions of the state where smoking rates are the highest. It is a direct project with health care providers and does not involve contracting with local health districts. The project targets low income women. The women are screened while still pregnant by their doctor's office or clinic. If they are found to smoke or live with a smoker, they are provided with educational packets which include information on smoking cessation. When the mother delivers, she will be screened again in the hospital maternity ward. Again, if she is still using tobacco, she is provided with a care package.

#### **c. Plan for the Coming Year**

The KISS pilot project will be evaluated and a decision will be made to expand the project statewide.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	20	19	13	12	11
Annual Indicator	13.7	13.8	13.8	9.1	9.1
Numerator	15	15	15	10	10
Denominator	109671	108796	108840	109731	109731
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	8.5	8.3	8.1	8	7.9

#### **Notes - 2006**

Not all death records for 2006 have been received. 2005 data is used as estimate for 2006.

#### **Notes - 2005**

2005 data not available until September 2006.

#### **Notes - 2004**

Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

#### **a. Last Year's Accomplishments**

Better Today's. Better Tomorrow's, (under a grant from the governor's office), is partnering with the Idaho Youth Suicide Prevention (YSP) Early Intervention Project, which is federally funded under the Garrett Lee Smith Memorial Act. Both projects are conducted by Idaho State

University Institute of Rural Health. YSP partners with Better Todays and other community organizations and agencies "to create an infrastructure for reducing suicide attempts and completions among Idaho Youth aged 10-24 regardless of ethnic/racial heritage." The anticipated activities include providing technical assistance to communities in implementing the TeenScreen depression/suicide risk screenings; supporting the Suicide Prevention Action Network (SPAN) Idaho's education efforts; supporting the SPAN chapters' local activities and building lasting statewide infrastructure for suicide prevention; preparing education/marketing tools for dissemination by the regional SPAN's; and conducting trainings and other outreach activities concerning suicide risk and programs for Native Americans, Hispanics and Asian/Pacific Islanders. An advisory committee of suicide prevention advocates was convened to advise ISU during the course of their activities.

Better Todays. Better Tomorrows is a program of Idaho State University Institute of Rural Health in partnership with NAMI-Idaho, the National Child Traumatic Stress Network and the National Institute for Mental Health. It has been named a promising practice by the National Child Traumatic Stress Network, SAMHSA and the National Association for Rural Mental Health and has been featured in *Advances in School-Based Mental Health Interventions* as well as Kirkwood, A & Stamm, BH (2006) *A Social Marketing Approach to Challenging Stigma*. *Professional Psychology: Research and Practice*, American Psychological Association Vol. 37, No. 5, 472--476. Better Todays. Better Tomorrows provided free trainings across the state that addressed children's mental health with new information on suicide prevention and child trauma and has consulted with other states on implementing the program in their areas.

Lastly, the Idaho Council on Suicide Prevention was formed by Executive Order No. 2006-08, by then, Governor, Dirk Kempthorne. Governor James Risch appointed the Council members in October 2006. The Council is responsible for the oversight of the Idaho Suicide Prevention Plan and its continued relevance. The Council submits an annual report to the legislature and the Governor's Office. SPAN is responsible for the administrative support for the Council. Two members of the Council represent the Idaho Department of Health and Welfare, the Division Administrator for Behavioral Health (mental health) and the Chief of the Bureau of Community and Environmental Health in the Division of Health. Better Todays Project Director Ann D. Kirkwood serves as chair of the Implementation Committee on the Council. The first Council meeting was convened on November 29, 2007. The second meeting was convened via a conference call on May 30, 2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Youth Suicide Prevention Early Intervention Coalition, a State-level public/private partnership.				X
2. Provide gatekeeper training for university residence hall staff, other student staff, and other community gatekeepers.				X
3. Continuation of TeenScreen.				X
4. Statewide suicide prevention referral sources will be available through 2-1-1 Idaho CareLine.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Idaho Youth Suicide Prevention Early Intervention Project continues to provide children/youth mental health education programs and trainings for caregivers and gatekeepers in partnership with Better Todays. Both programs continue to partner with the Department of Health and Welfare to conduct trainings surrounding children's mental health and suicide risks to law enforcement agencies statewide. Better Todays also consults with the Boise Police Department in creation of a Crisis Intervention Team, the first in Idaho.

Better Todays continues to conduct programs and trainings around children's mental health issues statewide. A total of 5,600 people have been trained since its inception in 2000. Better Todays also has translated its gatekeeper trainings into Spanish with 2 Spanish training sessions this year. A train-the-trainer program has been developed and is being promoted at this time. This year, Better Todays has presented findings at 5 national conferences.

The Idaho Council on Suicide Prevention continues to work on infrastructure, awareness, implementation and methodology committee issues. Currently, the Council is working on a project to collect information about what is happening in Idaho related to suicide and to collect better baseline data. A survey tool has been created, and it is expected that approximately 90 phone surveys will be conducted. Two meetings of the Council are scheduled for Fall 2007.

### **c. Plan for the Coming Year**

Better Todays will continue to partner with the Idaho Youth Suicide Prevention Project (YSP) in the upcoming year. Continued activities include distribution of best practices in suicide prevention to various cultural and ethnic groups, statewide virtual trainings in partnership with Telehealth Idaho for Spring 2008, and more community gatekeeper trainings through Better Todays. Trainings will reach first responders, survivors, advocates, parents, and other child-serving professionals. In addition to the trainings, mental health and suicide prevention information will be disseminated at Better Todays trainings and statewide conferences using table top displays. The project will also continue to partner with SPAN Idaho chapters to implement suicide prevention awareness campaigns across the state. Materials developed for the awareness campaigns include billboards, public service announcements, posters, and newspaper ads. Spanish language novellas are also being developed for the Hispanic Community and will be distributed in 2008.

Initial discussions with stakeholders in 2007 revealed omissions in the suicide data available in Idaho. Additionally, many community partners are eager to work on an effort to identify data sources, ascertain what data are needed for Idaho, identify data for use by Idahoans electronically and make recommendations for how to improve data collection statewide. In light of these discussions, a group of data experts is being convened in 2007 and will carry out the data analysis and make recommendations to the Idaho youth suicide prevention advisory group in 2008.

The Idaho Suicide prevention advisory group will continue to provide advice on grant activities during quarterly meetings. The group also promotes the use and establishment of best practices and helps to identify local suicide prevention and mental health resources.

YSP staff plan to submit an array of national evidence-informed programs to suicide prevention advocates, and assist community partners with resources and technical support in implementing these skill-building programs in their communities in 2008. A group of individuals from these communities will review the materials and programs revealed in our research. The next step will involve assisting these communities in implementation of the identified promising practices.

Finally, a determination needs to be made regarding where the Idaho Council on Suicide Prevention will be housed. It is under consideration for the Idaho Department of Health and Welfare, Division of Behavioral Health. Once that determination is made the plan for the coming year will be established.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	65	66	75	75	75
Annual Indicator	65.7	72.8	99	99	99
Numerator	132	142			
Denominator	201	195			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	75	75	75	75	75

**Notes - 2006**

Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

**Notes - 2005**

Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure.

**Notes - 2004**

Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 was entered to allow form to be saved.

**a. Last Year's Accomplishments**

Great strides were made in improving lay midwives knowledge about services available to their patients, important screenings and medical mile-markers. The Idaho Perinatal Project (IPP), who holds the contract for this project, continued to provide quarterly educational packets to all midwives throughout Idaho. These packets include books, DVD's, and additional timely information. The Idaho Perinatal Project's lending library has continued to expand, providing more information and resources for lay midwives throughout the state. The DVD 'Stages of Labor' is one example of such material. Three copies were distributed regionally to the Idaho Midwifery Council for their use. This year IPP was able to sponsor 4 lay midwives to attend their Winter Conference. In an informal survey, the need for education of HPV vaccine was identified. This was one breakout topic made available at the conference.

At the annual Nurse Summit meeting held in October of 2006, nurse managers in attendance (49) were asked for their input regarding progress made with this project over the past two years. Several examples were cited, such as greater communication with lay midwives, which offered a better continuum of care. The nursing director's mentioned seeing lay midwives bring patients

into the hospital earlier in their labor with identified problems or risks instead of waiting until it was a life-threatening situation. Regular meetings are being held between hospitals and lay midwives; in some areas, lay midwives are even attending staff meetings of hospital nursing staff. Overall, all nurses expressed increased efforts in communication and a level of trust being built between providers statewide.

The Perinatal Oral Health project kicked off in February in conjunction with the Idaho Perinatal Project Winter Conference. Dr. Kathy Phipps, a national expert on periodontal disease, spoke to a crowd of approximately 85 health professionals at the meeting. An additional session was held to bring key people from Idaho's medical community together to introduce the project and get feedback.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. Sexual and Reproductive Health Program will provide pregnancy tests and make referrals as appropriate.	X		X	
3. Continue Lay-midwife project with Idaho Perinatal Project.			X	X
4. Continue implementation of Oral Health for Pregnant Women Project.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

IPP is entering its 3rd year of the Lay Midwife Project. Innovative education/outreach activities are still being developed. One project that will roll out during the summer provides Mother's Journals. These journals are being provided to all midwives as a tool for educating both mom and caregiver, provide mom a place to journal about her pregnancy, provide information regarding fetal development, what to expect in the coming months, and questions that mom may want to ask her care provider. In conjunction with the journals, the midwife will receive information to address the questions in their quarterly education packets. These were timed to encourage the midwife to relay the information she is receiving as her patient is asking the questions.

The Midwifery Council drafted legislation which was presented to IPP. The IPP Board felt strongly that the present bill needed to be defeated. Several key people testified against it and it was defeated in committee.

The Perinatal Oral Health project is continuing to gain ground throughout the state. Health districts are educating obstetricians and dentists about the need to work together and establish referral networks for high risk pregnancies. One local health district conducted a survey of dentists to assess whether they would accept uninsured, Medicaid, and insured pregnant women. From the survey, a good list of dentists and their availability was developed. Names and information were provided to the Idaho CareLine.

#### **c. Plan for the Coming Year**

Funding will be provided, for at least one more year, to the IPP for continuation of this project. A sub-committee has been formed to develop draft legislation again in the year to come. Educational packets will be continued as well as a continued effort to build relationships, reduce the amount of high risk deliveries being attempted by lay midwives, and increase patient awareness of critical issues related to prenatal care.

The Perinatal Oral Health project will continue through contracts provided to local health districts. The main concern of obstetricians is that if they identify patients in need of dental care, they have nowhere to refer them if they are on Medicaid. Finding dentists who will take these patients in some capacity and providing that information to prenatal care providers statewide will continue to be the first steps in making this program a success.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	80.8	83	84	85	86
Annual Indicator	82.1	81.3	71.9	71.4	74.9
Numerator	16710	17091	15455	15889	16772
Denominator	20362	21012	21502	22245	22389
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	78	78.5	79	79.5	80

**Notes - 2006**

In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

**Notes - 2005**

In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

**Notes - 2004**

In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

#### a. Last Year's Accomplishments

During CY 2006, 30,702 women received counseling from the Sexual and Reproductive Health Program. Of those women, 2,043 were found to be pregnant. Those women who were pregnant were screened for high risk behaviors and referrals were made as indicated. All women were referred appropriately to obstetricians in order to begin early prenatal care.

A media campaign was launched to encourage women how to choose their prenatal care provider and to seek prenatal care early in their pregnancy. This campaign was sponsored by the Idaho Perinatal Project and ran primarily through radio. While it is difficult to measure the impact of a population based campaign such as this, data from the Pregnancy Risk Assessment Tracking System, PRATS, indicate that the percent of Idaho resident women who received prenatal care during the first trimester has increased significantly from 78.8% in 2003 to 86.9% in 2005. Data for 2006 is currently unavailable.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Sexual & Reproductive Health Program will provide pregnancy testing and referral for prenatal care.			X	
2. Utilize Pregnancy Risk Assessment Tracking System (PRATS).				X
3. The WIC Program will provide nutritional counseling and information on other pregnancy risk factors.			X	
4. The Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Due to funding and staffing issues, the comprehensive prenatal project was put on hold indefinitely. Components of the project continue, but linking them all together has not happened. Components include addressing perinatal depression, early prenatal care, dental care, smoking cessation, proper nutrition and substance abuse.

#### c. Plan for the Coming Year

Given that early prenatal care is an important issue for the March of Dimes, an opportunity to partner with them and the Idaho Perinatal Project will be explored.

### D. State Performance Measures

**State Performance Measure 1:** *Percent of mothers who were screened for post partum depression within one month following delivery.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
---------------------------------------	------	------	------	------	------

Annual Performance Objective					75
Annual Indicator			99	99	99
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	75	80	80	80	80

#### Notes - 2006

No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data. 99 has been entered to save form.

#### Notes - 2005

No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data.

#### Notes - 2004

No data is available at this time.

#### a. Last Year's Accomplishments

A needs assessment was conducted at the Idaho Perinatal Project's annual Nurse Summit meeting. This discussion centered on what is currently being done in birthing hospitals throughout Idaho with regard to postpartum depression (PPD). As follow up to the discussion, the nurse managers were asked to submit their tools and processes to piece together a method that might work better or share best practices with those hospitals that did not have an established screening program. It was determined that each hospital is very different but that the greatest need was someplace to refer at-risk mothers.

Work was done in collaboration with the Governor's Council for Families and Children and the Division of Family and Community Services within the Department of Health and Welfare on a grant targeting PPD. The idea behind the grant was to begin building the infrastructure and systems in rural parts of the state to have professionals able to assist women with counseling utilizing hospitals presently exist in counties statewide. This grant was not funded however.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete needs assessment to identify use of screening tools.				X
2. Develop project centered on post-partum depression to identify and address barriers facing women with post-partum depression.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

A presentation will be given at the 2007 Nurse Summit Meeting to provide the results of the Needs Assessment and move forward with providing resources to rural hospitals. Because PPD in Idaho is a high priority, partners throughout the state continue to look for ways to improve the system.

### c. Plan for the Coming Year

Local health districts have a desire to address PPD in their offices in the way of increased screening, however, the system will continue to lack the infrastructure for referral until something changes. In 2006, a new Division within the Department of Health and Welfare was established. This new Behavioral Health Division will be approached to partner with current stakeholders to begin addressing systems building and provide support for such a program.

Current Pregnancy Risk Assessment Tracking System (PRATS) data indicate that Hispanic women reported significant symptoms of PPD (79%), with PPD occurring in non-Hispanic women in 62.9% of respondents. This indicates a need to address minority issues when developing a program related to PPD.

**State Performance Measure 2:** *The percent of Medicaid and SCHIP children ages 1 and 2 that received the expected number of EPSDT screens.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					75
Annual Indicator				70.5	67.4
Numerator				16834	16430
Denominator				23865	24390
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	75.2	75.4	75.6	75.8	76

#### Notes - 2006

Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Form 17 HSC 02 and 03 combined.

#### Notes - 2005

Entered values match Form 17 HSC 02, which reflects medicaid only and less than 1 year of age.

### a. Last Year's Accomplishments

The annual report of the State Children's Health Insurance Plans revealed a dramatic change in the percent of children receiving EPSDT screens. As previously noted, it was suspected that the state's very low percentage of 'children 0-24 months with the number of well child checks expected' (32%) was related to a flaw in Medicaid's database. The system underwent reprogramming and the EPSDT rate for 2006 was reported at 95%. The system will continue to be evaluated for validity each year to determine the accuracy of the data being reported.

As part of Medicaid Modernization implemented in July Of 2006, the reimbursement rate to PCP's for well child exams was increased to match commercial rates. At this time the participant handbook was also updated. The first benefit highlighted in the Basic Plan is "Prevention" and encourages parents to take their children to their PCP for well child exams. For SCHIP children (those that have to pay premiums), a Preventive Health Assistance (PHA) benefit was instituted.

Under this benefit, parents can earn points that can be used to offset any delinquent premiums by keeping their children's well child exams and immunizations up-to-date.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increases in reimbursement for well child (EPSDT) screenings.				X
2. Education of providers and parents regarding changes to Medicaid modernization.		X		
3. Continue referral as necessary for children who do not have a regular health care provider.		X		
4. Reminder letters sent to all children enrolled in Medicaid.		X		
5. Enhance preventive services targeted to young children and families through Medicaid.	X			X
6. Continue monitoring Medicaid data to evaluate number of children receiving appropriate screens.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Medicaid has put more effort into educating providers this year with changes related to Medicaid Modernization. One area that has specifically been addressed is related to a misunderstanding of Medicaid's schedule for well child exams. Idaho has always followed the American Academy of Pediatrics periodicity chart. However, the provider handbook had not been updated for several years to reflect any changes to this chart. An updated version of the provider handbook was published in May of 2007 and reflects an additional number of recommended examinations.

During the spring, training was developed and presented statewide to a mixed audience of Family and Community Services regional staff, providers and advocates. The importance of well child exams was emphasized as the starting point for any extended benefits a child might need. This same presentation was given at the Systems of Care Conference on EPSDT.

Data continues to be monitored to assure that there is not an immunization disparity in the Medicaid population as compared to the general population. Data for this current year suggest that all immunization rates went down, but that Medicaid children and non-Medicaid children are equally immunized.

**c. Plan for the Coming Year**

Education of parents and providers with regard for the importance of well child checks will continue to be a high priority given the focus of prevention with Medicate Modernization.

**State Performance Measure 3:** *Percent of 9th - 12th grade students that report having engaged in sexual intercourse.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
---------------------------------------	------	------	------	------	------

Annual Performance Objective					
Annual Indicator			38.5	39	39
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	36.5	36	35.5	35	34.5

#### Notes - 2006

YRBS Survey not conducted in 2006

Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006  
used as estimate for 2006

Numerator and denominator not available

#### Notes - 2005

2005 YRBS Survey Data available in June 2006.

Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006

Numerator and denominator not available

#### Notes - 2004

YRBS survey not completed in 2004.

#### a. Last Year's Accomplishments

Reproductive health clinics around the state served a total of 3,465 teens ages 15 - 17 in CY2006. These clients all received physical assessment, education and counseling services. Idaho's teen pregnancy rate is provisionally 18.8 compared to the CY2005 rate of 16.8 for 15-17 year olds.

All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STD prevention.

The Idaho Sexual and Reproductive Health Program spent most of last year without a program manager.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support local health district advisory boards, which guide education materials and outreach.		X	X	
2. Ada County Juvenile Detection Center project.			X	
3. Reproductive health information through high school classes.		X		
4. Partner with local youth peer mentoring program, "Youth in the Know."				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

All of the local health districts have active advisory boards within their reproductive health programs which guide the content of education materials and provide direction for outreach activities. All of these advisory boards have committee members of various backgrounds such as faith based members as well as teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups.

All health districts provide extended clinic hours in the evening in order to accommodate teen clients. Confidential family planning services are provided for teens in all Idaho Title X clinics.

### c. Plan for the Coming Year

A new Sexual and Reproductive Health program manager started on January 2, 2007. She has successfully filled 2 of three existing vacancies. The program is beginning to stabilize which results in improved program integration both at the state and local level.

The Ada County Juvenile Detention Center project will continue which provides access to reproductive health care services for high-risk male adolescents. Residents will be given the opportunity to receive services through weekly preventive reproductive health clinics. Pre and post test evaluations will be given to measure the level of intention to the change of risky sexual behaviors.

### **State Performance Measure 4:** *Percent of 9th – 12th grade students who used any type of tobacco in the past 30 days*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					0
Annual Indicator		17.8	17.8	21.4	21.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	0	0	0	0	0

#### **Notes - 2006**

YRBS not conducted in 2006, 2005 results used as estimate for 2006.

Based on YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

#### **Notes - 2005**

2005 YRBS data available in June 2006.

Based on YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

#### **Notes - 2004**

YRBS not conducted in 2004, results from 2003 used as estimate for 2004.

**a. Last Year's Accomplishments**

Project Filter continued to support the American Lung Association of Idaho in implementation of the Teens Against Tobacco Use (TATU) program in Idaho schools. Project Filter supports the American Lung Association's efforts to implement TATU through our contract with local Health Districts. The TATU program trained approximately 400 high school students as peer educators who saw over 8,600 elementary and junior high school students. Students are also reached through on campus marketing efforts and school announcements. Peer Educators are trained in the TATU tobacco prevention curriculum and receive training on presentation skills.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate and implement TATU program in 5 of 7 health districts.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Project Filter supported 5 of 7 Health Districts in working in collaboration with the American Lung Association in the implementation and coordination of their TATU program in rural high schools in Idaho. No other activities are planned for this year.

**c. Plan for the Coming Year**

Project Filter will once again be working with the American Lung Association of Idaho and the local public health districts to further coordinate and implement TATU in Idaho schools. Program focus will continue to be on underserved rural schools in Idaho while maintaining TATU groups at existing schools.

**State Performance Measure 5: *Percent of pregnant women who received dental care during pregnancy.***

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					50
Annual Indicator			39.3	43.6	43.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional

	2007	2008	2009	2010	2011
Annual Performance Objective	45	45	46	46	46.5

#### Notes - 2006

Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses with unknown data were not included in the denominator.

#### Notes - 2005

Data source is 2005 Idaho PRATS survey. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses with unknown data were not included in the denominator.

#### Notes - 2004

Responses with unknown data were not included in the denominator.

Note: PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho.

#### a. Last Year's Accomplishments

The Perinatal Oral Health project kicked off in February in conjunction with the Idaho Perinatal Project Winter Conference. Dr. Kathy Phipps, a national expert on periodontal disease, spoke to a crowd of approximately 85 health professionals at the meeting.

Contracts were established with the local health districts to begin building relationships with dentists and obstetricians and get them working together. As part of the kick-off for this project, representatives from each health district attended a one day training about the program and how to get the project started in each of their districts. Several follow up conference calls were held throughout the year to make sure everyone was gaining ground. Most districts chose lunch and learn sessions as their first steps in bring dentists, obstetricians and other key people together to heighten awareness about the need for such a program. Several began establishing partnerships in a short period of time.

To assist the health districts in launching this program, new educational materials were designed and provided that focused on dental health during pregnancy and the overall benefits. These materials targeted pregnant women.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish referral network for physicians and dentists.				X
2. Conduct survey of dentists regarding acceptance of Medicaid referred patients.			X	X
3. Continue evaluation of PRATS and Idaho Birth Certificate data.				X
4. Continue to improve dental coverage for pregnant women through Medicaid.				X
5. Educate providers and pregnant women regarding link between good oral health and improved birth outcomes.			X	

6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The Perinatal Oral Health project is continuing to gain ground throughout the state. Health districts are educating obstetricians and dentists about the need to work together and establish referral networks for high risk pregnancies. One local health district conducted a survey of dentists to assess whether they would accept uninsured, Medicaid, and insured pregnant women. From the survey, a good list of dentists and their availability was developed. Names and information were provided to the Idaho CareLine.

Information regarding prenatal oral health is being disseminated through WIC clinics, pregnancy ancillary care programs (PAC), dentist offices and OB clinics. The awareness has greatly increased. Many districts are in the process of identifying local champions to lead the way and bring other health care professionals on board. Developing useful and complete referral networks continues to be one of the main goals at this point of the project.

Data collection regarding the number of women who are told about the need for dental care while pregnant and the percent who seek dental care continues through the annual Pregnancy Risk Assessment Tracking System. At this time there are no comparative data available to determine if awareness of the need is reaching the pregnant woman.

#### **c. Plan for the Coming Year**

The Perinatal Oral Health project will continue through contracts provided to local health districts. The main concern of obstetricians is that if they identify patients in need of dental care, they have nowhere to refer them if they are on Medicaid. Finding dentists who will take these patients in some capacity and providing that information to prenatal care providers statewide will continue to be the first steps in making this program a success.

#### **State Performance Measure 6: Percent of Medicaid and SCHIP children who are fully immunized by age 2.**

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					90
Annual Indicator				80	80
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	90	90	90	90

#### **Notes - 2006**

#SP6 Notes – 2005

Data is an estimate from IRIS data.

Notes – 2006

Data is an estimate from provider visit assessments

#### **Notes - 2005**

Data is an estimate from IRIS data.

**a. Last Year's Accomplishments**

The Idaho Immunization Program has been conducting immunization coverage assessments of Medicaid children age 24-35 months of age annually since 2000. This effort was part of a national collaboration between the CDC and CMS to identify at risk Medicaid children and target immunization efforts where possible. Data consistently showed that Idaho Medicaid children were significantly under-immunized (up to 15% difference in rates) when compared to non-Medicaid or privately insured children. Children enrolled in the WIC program were also assessed to determine what role if any, WIC played in immunization rates of its clients. It was determined that the WIC program had a positive impact on rates and that in fact may have been inflating the Medicaid immunization rate as the populations have no clear dividing line. This prompted research to identify where the problem lay and what could be done to address the issue. A position paper was drafted which provided recommendations.

Beginning in 2006, the Idaho Immunization Program modified the information collected in physician's offices during a scheduled quality assurance visit to include the Medicaid status of each patient assessed. This information was collected by individual provider and merged at the end of the year and assessed by Medicaid status to determine the immunization rate for each population. Preliminary data indicates there is no significant difference between Medicaid and non-Medicaid children with rates of 72% and 75% respectively for the 4:3:1:3:3 (4 DTap, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B) series.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing evaluation of the Medicaid population's immunization rate through chart review.				X
2. Ongoing evaluation of the state immunization rate for all children.				X
3. Referral for immunization through WIC link linkage.				X
4. Educate public regarding immunization awareness.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Idaho Immunization Program is continuing to monitor the data. The IIP has established protocols which include collecting Medicaid status of each patient assessed. This data is entered into Co-CASA and analyzed.

**c. Plan for the Coming Year**

Even though the data suggests that Idaho Medicaid children are as immunized as the non-Medicaid children, the Bureau of Clinical and Preventive Services and the Idaho Immunization Program (IIP) will continue to monitor the data. Should we start to see a difference in the rates between Medicaid children and non-Medicaid children, steps will be taken to address the difference.

**State Performance Measure 7:** *Percent of 9th – 12th grade students that are overweight.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					0
Annual Indicator		7.4	7.2	7	7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	0	0	0	0	0

**Notes - 2006**

YRBS not conducted in 2006

Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006  
used as estimate for 2006

Numerator and denominator not available

**Notes - 2005**

2005 YRBS survey data available in June 2006.

Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006

Numerator and denominator not available

**Notes - 2004**

YRBS survey not performed in 2004.

Results from 2003 YRBS used as estimate

Numerator and denominator not available

**a. Last Year's Accomplishments**

Universal "core messages" for physical activity and nutrition were finalized, with accompanying graphic icons. Starting with an umbrella message of "Do It for Life!," messages for nutrition ("Enjoy Nutrient-Rich Foods"), physical activity ("30/60 Every Day"), weight management ("Energy In/Energy Out"), and behavior change ("Small Steps=Big Changes") were developed and test marketed.

Two 30-second television commercials were developed, aimed at families with children ages 5-14. One spot emphasized healthy eating and the other increased physical activity for kids. The call to action for both was to call the Idaho 2-1-1 CareLine for a free "Healthy Habits, Healthy Families" 2007 calendar. The calendar was developed and printed, and is an interactive tool with dozens of tips for a family to become more active and better nourished.

The "Healthy Habits" calendar was also distributed to and used by local health districts in implementing their individual work plans.

Technical assistance was made available to school districts desiring assistance with drafting and/or implementation of school wellness policies.

A state kickoff of the "Fruits & Veggies--More Matters" national campaign to increase fruit and vegetable consumption was held at an Albertson's store in the Boise area.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop media campaign to encourage families to become more active and eat better using Idaho CareLine.		X		
2. Technical assistance will be made available to schools regarding their school wellness policies.				X
3. Formalize a state Physical Activity and Nutrition Alliance/Coalition.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

A "Healthy Habits, Healthy Families Handbook" with similar content to the calendar, was developed and is being printed and distributed to local health districts, the Idaho 2-1-1 CareLine, and other partners.

A surveillance project to determine the prevalence of overweight elementary-aged children in Idaho is being designed and will be implemented next school year.

An organizational meeting of the state Physical Activity and Nutrition Alliance was held in May 2007 and further organizational efforts are ongoing.

**c. Plan for the Coming Year**

We will translate the "Healthy Habits" calendar and handbook products into Spanish, and develop both an English and Spanish version of a core message handout for educational use.

We will work with the Idaho Commission for the Blind and Visually Impaired to improve the nutritive value of vending machine offerings in state buildings.

We will work with the Department of Administration and Division of Professional-Technical Education to enhance the state employee wellness program.

We will work with partners to create a plan to promote the "Fruits & Veggies--More Matters" message.

We will work with local health districts and other partners to improve the quality of "competitive foods" in schools and to enhance physical activity opportunities in the schools.

**E. Health Status Indicators**

The health status indicators provide quite comprehensive demographic information as well as select birth, death and condition information. While all of this information is available elsewhere, it consolidates key measures of significance to the MCH population and program in one area.

This data allows us a comprehensive picture of who current funding is affecting either directly or indirectly. Through the evaluation of outcomes from each of these programs or areas, we are able to weigh the impact of our funding and shift funds as necessary in order to serve the most individuals at highest risk. While this state level data points may assist in program direction, Idaho efforts such as the expanded PRATS survey make it possible for us to look at the issues at a more local level.

Surveillance of these key indicators allows us to monitor our progress in relationship to other MCH programs. The indicators are not particularly useful for evaluation purposes.

## **F. Other Program Activities**

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Idaho has made the decision to consolidate PKU services under one physician in effort to provide consistent care from birth through 18. Dr. Ron Scott will discontinue staffing Idaho clinics during the summer of 2005 and Dr. Cary Harding from Oregon Health and Science University will be taking his place. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.

The MCH research analyst, Greg Seganos, and the MCH special Projects Coordinator, Traci Berreth, have recently completed the publication of the Bureau of Clinical and Preventive Services outcome performance measures. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

The Idaho Fit Kids Project is a year long pilot project focusing on the use of BMI as a predictor of risk for overweight in children and providing families with helpful tips on health. The Division of Health contracted with the District Health Departments in the state to provide training to pediatrician and family practice offices in their service area. The trainings include factual information on BMI, ideas for incorporating BMI into practice and how to provide parents with guidance related to their child's healthy growth.

Each Health District has been contracted to provide up to 25 trainings between March 1, 2005 and October 31, 2005. The Division of Health provided training to the Health Districts regarding this project in January 2005.

Through the trainings provided by the Health Districts, physician offices will receive "Idaho Fit Kids" handouts for patients, CDC growth grids, and a card for families to mail to the Department of Health and Welfare if they would like to receive more information related to healthy growth. The families who return the request for information card will receive a series of 6 newsletters in the mail from the Division of Health. The newsletters will contain tips on eating healthy and activity.

To date, the Health Districts have trained over 30 physician offices in the state.

Evaluation will take place in January 2006 and will include:

1. Chart review of physician offices which received training to measure whether or not BMI was assessed.

2. A written survey will be mailed to families who requested more information for the purpose of determining if they found the information helpful.

3. Physician offices will be asked to complete a brief survey during January 2006 related to the project.

/2007/ Through the Idaho Fit Kids Project the Health Districts trained 141 physician offices in the state. 125 families requested additional information through a series of newsletters. Evaluation is currently underway and will be completed by the end of calendar year 2006.

1. Chart reviews are being conducted in the physician offices which received the training to measure whether or not BMI was assessed.

2. Physician offices are being asked a few questions regarding the project using an interview format. This interview is occurring at the same time of the chart review

3. Written surveys are being distributed to the families who requested more information for the purpose of determining if they found the information helpful.

Follow-up projects will be considered based on the project evaluation results. //2007//

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 34,190 children grades 1-6 in 2004. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 51,747.

/2007/ The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 33,754 children grades 1-6 in 2005. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 56,795. //2007//

The MCH Oral Health Program continues to fund early childhood caries (ECC) prevention and fluoride varnish projects for WIC clients, Head Start children, and children who are Medicaid/CHIP eligible. During 2005, 13,323 children received preventive dental services, including 3,020 who received fluoride varnish applications, and 7,382 parents, teachers, dental and medical health professionals served through education and community outreach efforts.

The State Oral Health Collaborative Systems (SOHCS) Grant to integrate oral health with well child care was implemented during 2005 in southwest Idaho. Trainings in early childhood caries prevention and fluoride varnish application were provided to 36 dental and 93 medical professionals, including the Family Practice Residency of Idaho faculty, residents and nursing staff; St. Luke's Cystic Fibrosis Clinic nurses; the Ada Canyon Medical Education Consortium; health district immunization clinic nurses; and private practice dentists, physicians and staff. The project also included media outreach to an estimated 51,120 women age 18-34 years through public service announcements developed in partnership with Idaho Oral Health Alliance members.

The Oral Health Program helped convene the Idaho Head Start Oral Health Forum in November 2004. Forum follow-up included development of an Idaho Head Start Oral Health Action Plan and motivational interview trainings with a focus on oral health, presented by Dr. Philip Weinstein, University of Washington, during September 2005. The motivational interview trainings were held in six population areas of the state and were attended by 244 Head Start, WIC and district dental staff. A smile survey of Idaho Head Start children is currently underway.

The 2005 Idaho State Smile Survey collected oral health data on 6,300 kindergarten, third and sixth grade students.

## **G. Technical Assistance**

The Idaho Oral Health Program may request technical assistance to support the prenatal oral health project that is currently in the planning stages for implementation in FY 2006.

The goal of the project is to integrate oral health with prenatal care. The target population is pregnant women, particularly those served through the Medicaid Program. The Idaho Medicaid Program pays for approximately 40% of all deliveries. Efforts will be made to engage both medical and dental care providers in the effort. Project partners will include the Medicaid Healthy Connections Program, the District WIC and Oral Health Programs, as well as representatives of professional and community organizations with an interest in maternal and child health.

Project objectives are to increase awareness of the link between oral health and birth outcomes and increase access to periodontal care that can improve pregnancy outcomes. Medicaid data on dental access and costs associated with deliveries and preterm births will serve as a baseline for project evaluation.

Plans are to bring together key stakeholders for a brainstorming session to present the project proposal, get input, and form a state leadership team. If a technical assistance request is submitted, it will be to bring in a consultant to participate in the brainstorming session, advise the leadership team, and to provide continuing education for project partners on the science linking oral health to birth outcomes and the safety of providing dental services during pregnancy. We anticipate both state and district level trainings could require technical assistance.

## **V. Budget Narrative**

### **A. Expenditures**

#### **Annual Expenditures**

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

Funds used for state match during federal fiscal year 2006 are from the Immunization Program. State general fund in the amount of \$2,150,382 were used to purchase vaccine for children. This funding commitment allows the state to maintain universal status where all children regardless of income or insurance status have access to free vaccine. The other portion of MCH grant match comes from local Immunization Program funds in the amount of \$59,458. These funds are used for immunization education and outreach and for conducting local immunization clinics.

The expenditures in FFY 06 that were directed to Pregnant Women including 25% of the MCH administrative budget (\$50,246), Pregnancy Risk Assessment Tracking system (\$71,338), 25% of the Office of Epidemiology and Food Protection MCH budget (\$59,153), 20% of the Reproductive Health MCH budget (\$120,498), and 25% of the Idaho CareLine MCH budget (\$7,363).

Funds used in FFY 05' for Infants < 1 Year Old included 25% of the MCH administrative budget (\$50,246), 25% of the Office of Epidemiology and Food Protection MCH budget (\$59,153), 25% of the Idaho CareLine MCH budget (\$7,363), 50% of the Immunization Program state and local funds used for block grant match (\$1,104,920), provides funds to cover, and newborn hearing screening (\$7,131).

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget (\$50,246), 25% of the Office of Epidemiology and Food Protection MCH budget (\$59,153), 25% of the Idaho CareLine MCH budget (\$7,363), 50% of the Immunization Program state and local funds used for block grant match (\$1,292,806), the Oral Health Program (\$435,456), and 40% of the MCH budget for Reproductive Health (\$240,998).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget (\$50,247), 25% of the Office of Epidemiology and Food Protection MCH budget (\$59,153), 25% of the Idaho CareLine MCH budget (\$7,362), the Genetics Program (\$189,547) and the Children's Special Health Program (\$760,108).

40% or \$240,998 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age. And \$347,447 in indirects was included in expenditures for the Administrative budget.

FFY 06 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget (\$170,592), the Reproductive Health Program Budget (\$602,494) and the Children's Special Health Program budget (\$760,108). The two programs included under enabling services was the Idaho CareLine (\$29,451 ) and 10% of the MCH money supporting the STD program. Programs included in the Population-Based Services category were Oral Health (\$435,456), Immunizations (\$2,529,877 - state and local match), and Newborn Hearing Screening (\$7,131). Programs included under infrastructure Building Services included: MCH Administration (\$200,985), Pregnancy Risk Assessment Tracking System (\$71,338), Office of Epidemiology and Food Protection (\$236,612), 10% of the Genetics Program (\$18,955), and the indirect budget (\$347,447).

Total reported MCH expenditures for Idaho during FFY 06 are \$5,156,292.

## **B. Budget**

### **Budget Narrative**

To meet the match requirement the state will be utilizing \$2,150,381 in state general fund and \$379,496 in local funds.

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children and women of child bearing age, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 39% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Epidemiology.

An area we had focused additional funding on was Idaho's Pregnancy Risk Assessment Survey. Data from previous years provided an overview of perinatal issues statewide, but by increasing the sample size we are now able to identify trends in specific areas of the state. We will begin using this valuable data to guide program direction and project development.

A good working relationship continues to grow between Idaho Perinatal Project team and midwives in the state. Based on the results of the birth complications survey, the Project is planning to move forward with seeking legislation to ensure the best possible birth outcomes for all infants born in Idaho.

The Idaho Perinatal Oral Health project has been well received. This project targets primary care providers, dentists and others professionals in the community to increase awareness on the importance of a dental visit during the second trimester. The project will also work toward improving the awareness among females of reproductive age about the importance of dental care during pregnancy. \$50,000 has been allocated to this project, and it will be administered through the oral health program. In past year a statewide media campaign and educational pieces were produced. The goal is to develop a referral infrastructure within communities that can be sustained without continued MCH funding.

This past year the WIC Program is completed a project to assist employers in becoming breastfeeding friendly by supporting mothers who are nursing. This project was a train-the-trainer format with breastfeeding coalitions around the state in an effort to increase local level expertise. The estimated cost of the project was \$30,000. Total cost was approximately \$10,000. The lower than expected cost was because not all councils participated. Three of the 7 councils participated as well as one health insurance company. This project has well received and garnered some positive press coverage.

The above mentioned projects are directly intended to create systems change. This allows the federal MCH dollars to be invested for only a short period of time with long term benefits to the overall system caring for pregnant women and children.

One area that the State has made progress on over the past year is transitioning Idaho's Children Special Health Program away from being primarily an insurance plan to focusing on care coordination for the uninsured and ensuring reasonable access to specialty care throughout the state. This is the first step to a longer term plan of ensuring access to care and health care system navigation for all families of children with special health care needs, not just those covered by Idaho's current program. CSHP has stayed within budget but has continued to have a difficult time with billing issues. The billing issues are being addressed and CSHP is now in a good position as we move into Medicaid reform here in Idaho. Future projects will include the development of a CSHP website and database, program evaluation and continued work with

various agencies, organizations and policy makers to develop the future role for MCH and CSHP.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.